BENEFIT PLAN

Prepared Exclusively For
Texas Operators Association

Open Access Network Only Plus-$500 Plan

What Your Plan Covers and How Benefits are Paid

Texas Health + Aetna Health Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Texas Health + Aetna Health** Life Insurance Company and the Policyholder

Texas Health® | aetna®

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

Exclusive Provider Disclosure Notice

- An exclusive **provider** benefit plan provides no benefits for services you receive from **out-of-network providers**, with specific exceptions as described in your policy and below.

- You have the right to an adequate network of preferred **providers** (known as "network providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

- If your insurer approves a referral for out-of-network services because no preferred **provider** is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred **provider's** bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.

- You may obtain a current **directory** of preferred **providers** at the following website: www.texashealthaetna.com or by calling **Texas Health + Aetna Health** Member Services at the toll-free number on your ID card for assistance in finding available preferred **providers**. If the you relied on materially inaccurate **directory** information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

Open Access Network Only Plus Medical Plan

Booklet-certificate

Prepared exclusively for:

Policyholder:	Texas Operators Association
Group policy number:	GP-170207-A
	Booklet-certificate 2
Group policy effective date:	January 1, 2021
Plan effective date:	January 1, 2021
Plan issue date:	March 8, 2021

Important note:
The insurance policy under which this certificate 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 Texas Health + Aetna Health Insurance Company

Welcome

Thank you for choosing **Texas Health + Aetna Health**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Texas Health + Aetna Health** plan for in-network coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become insured, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it takes the place of all certificates describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Texas Health + Aetna Health Insurance Company** ("**Texas Health + Aetna Health**") and the policyholder. Ask the policyholder if you have any questions about the **group policy**.

Oh, and each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Texas Health + Aetna Health** plan for in-network coverage.

Table of Contents

Schedule of benefits Issued with your booklet-certificate

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents.
- When we say "us", "we", and "our", we mean **Texas Health + Aetna Health**.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network coverage for medical, vision and pharmacy insurance coverage.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- Generally will pay only when you get care from **providers** in our network of doctors, **hospitals**, and other **providers**.

1. **Eligible health services**
   Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

   So what are **eligible health services**? They are health care services that meet these three requirements:
   - They are listed in the *Eligible health services under your plan* section.
   - They are not carved out in the *What your plan doesn't cover – some eligible health service exceptions* section. (We refer to this section as the "exceptions" section.)
   - They are not beyond any limits in the schedule of benefits.

2. **Providers**

Texas Health + Aetna Health's network of doctors, **hospitals** and other health care **providers** are 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 into your Plan Benefits secure member website at www.texashealthaetna.com.

You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**.

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

3. **Service area**

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

Important note for dependents under a qualified medical support order: 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 living 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.

4. **Paying for eligible health services– the general requirements**

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**.
- You get the **eligible health service** from a **network provider**.
- You or your **provider preauthorizes** the **eligible health service** when required.

You will find details on **medical necessity** and **preauthorization** requirements in the *Medical necessity and preauthorization requirements* section.

5. **Paying for eligible health services– sharing the expense**

Generally your plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

6. **Disagreements**

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “independent review organization” or IRO for short, will make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

How to contact us for help

We are here to answer your questions. You can contact us by logging onto your Plan Benefits secure member website at www.texashealthaetna.com.

Register for Plan Benefits member website our secure internet access to reliable health information, tools and resources. Plan Benefits member website online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Texas Health + Aetna Health** Member Services at the toll-free number on your ID card.
- Writing us at **Texas Health + Aetna Health Insurance Company**, 612 East Lamar Boulevard, Suite 100, Arlington, TX 76011.

Your member ID card

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven’t received it before you need **eligible health services**, or if you’ve lost it, you can print a temporary ID card. Just log into your Plan Benefits secure member website at www.texashealthaetna.com.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

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

When you can join the plan

As an employee you can enroll yourself and your dependents if you live or work in the **service area**:

- At the end of any waiting period the policyholder requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse
- Your dependent children – your own or those of your spouse
  - The children must be under 26 years of age, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption and any child when you become a party in a suit to adopt the child.*
    - Foster children
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you and whether or not the child resides inside the **service area**)
    - Grandchildren in your court-ordered custody
    - A grandchild who, at the time of application, is your dependent for federal tax purposes
    - Any other child with whom you have a parent-child relationship

*Your adopted child may be enrolled as shown in the *When you can join the plan* section at your option, after the date:

- You become a party in a suit for adoption, or
- The adoption becomes final

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask the policyholder when benefits for your spouse will begin. It will be:
    - No later than the first day of the first calendar month after the date we receive your completed enrollment information and
    - Within 31 days of the date of your marriage.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive verbal or written enrollment information, Or, you can call 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.
- An adopted child - A child that you, or that you and your spouse adopts is covered on your plan for the first 31 days after you become party in a suit to adopt the child or the adoption is complete.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after you become party in a suit to adopt the child or the adoption is complete.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- A stepchild - You may put a child of your spouse on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage with your stepchild's parent.
  - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.
- Children you are responsible for under a qualified medical or dental support order or court order (whether or not the child resides with you) – A child you are responsible for under such a support order is automatically enrolled for the first 31 days after we receive such order or notice of such order.
  - To keep your child covered, you must complete enrollment information within 31 days after we receive such order or notice of such order from your employer.
  - If you miss this deadline, your child will not have vision benefits after the first 31 days.

Notification of change in status

It is important that you notify us of any changes in your benefit status. This will help us effectively deliver your benefits. Please notify us as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other health plan of any covered dependent

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- When a court orders that you cover a current spouse or a minor child on your health plan.
- Your employer offers multiple health benefit plans and you chose a different health plan during open enrollment.
- Your child no longer has coverage under the Child Health Plan for Certain Low-Income Children Program or Title XIX of the Social Security Act (other than coverage solely for benefits under the Program for Distribution of Pediatric Vaccines).

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for health benefits.

Medical necessity and preauthorization requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services.** See the *Eligible health services under your plan* and *exceptions* sections plus the schedule of benefits.

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

- The **eligible health service** is **medically necessary**.
- You or your **provider preauthorizes** the **eligible health service** when required.

This section addresses the **medical necessity** and **preauthorization** requirements.

Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**". That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

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.

Preauthorization

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

In-network

Your **physician** is responsible for obtaining any necessary **preauthorization** before you get the care. If your **physician** doesn't get a required **preauthorization**, you will only have to pay your applicable **deductible** and/or **copayment**/**coinsurance**. If your **physician** requests **preauthorization** and we refuse it, you can still get the care but the plan won't pay for it. You have the right to appeal this decision. See the *When you disagree – claim decisions and appeal procedures* section.

You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

Preauthorization should be secured within the timeframes specified below. For **emergency services**, **preauthorization** is not required, but you should notify us within the timeframes listed below. To obtain **preauthorization**, call us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **preauthorization** at least three days before the date you are scheduled to be admitted.
For an emergency admission:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. 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 an **injury**.
For outpatient non-emergency medical services requiring **preauthorization**:	You or your **physician** must call at least three days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your **physician** of the **preauthorization** decision**,** where required by state law. If your **preauthorized** services are approved**,** the approval is valid for 60 days as long as you remain enrolled in the plan**.**

When you have an inpatient admission to a facility, we will notify you, your **physician** and the facility about your **preauthorized** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be **preauthorized**. You, your **physician**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **preauthorization** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You or your **provider** may request a review of the **preauthorization** decision. See the *When you disagree - claim decisions and appeals procedures* section.

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

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically.**

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.

Contact us or go online to get the most up-to-date **precertification** requirements and list of **step therapy** drugs Sometimes you or your **provider** may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

Please see the *When you disagree - claim decisions and appeal procedures* section for more information on your appeals rights in these situations.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exceptions in the *exceptions* section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Important note:
Sex-specific **eligible health services** are covered when medically appropriate, regardless of identified gender.

Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - 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 these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer

screenings, contact your **physician** or contact Member Services by logging on to your Plan Benefits secure member website at www.texashealthaetna.comor at the toll-free number on your ID card. This information can also be found at the www.HealthCare.govwebsite.

Routine physical exams

Eligible health services include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.

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 • Prostate specific antigen (PSA) tests	• 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 • Behavioral assessments 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	• 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 newborns • Height, weight and body mass index measurements 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

Routine physical exams for children from birth to age 18	
• Obesity screening and counseling • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Tuberculin testing for children at higher risk of tuberculosis	• 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 • A gynecological exam that includes a rectovaginal pelvic exam for women who are at risk of ovarian cancer) • 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 sections, 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 Immunodeficiency 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-woman visits to obtain recommended preventive services

Eligible health 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.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration.
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Preventive care immunizations

Eligible health services include 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 influenzae 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 the child by law

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

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician, PCP,** obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. 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**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**
  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits;
  - Tobacco cessation prescription and over-the-counter drugs
    - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms (All forms of low-dose mammography, including digital mammography and breast tomosynthesis)
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

Unless otherwise stated in the *Schedule of Benefits*, these benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a **network provider** who is an OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as preventive care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's**, **PCP's,** OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

Breast feeding durable medical equipment

Eligible health services include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every 3 years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous 3 year period, the purchase of another electric breast pump will not be covered until a 3 year period has elapsed since the last purchase.

Breast pump supplies and accessories

Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

Eligible health services include counseling services provided by a **physician**, **PCP**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices

Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

Voluntary sterilization

Eligible health services include 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.

Important note:
See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

Physicians and other health professionals

Physician services

Eligible health services include services by your **physician** to treat an **illness** or **injury**. You can get those 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**

Important note:
Your policy covers **telemedicine** or **telehealth** only when you get your consult through a **provider** that has contracted with **Texas Health + Aetna Health** 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.

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

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

Physician surgical services

Eligible health 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**

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided at **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health 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 or PCP** services and not for a separate fee for facilities.

Dental care services and anesthesia in a hospital or surgery center

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

- Have a 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

Home health care

Eligible health services include home health care services 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 your needing to stay in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, furnishing of medical equipment and supplies (other than drugs or medicines) or are short-term speech, physical, respiratory 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 conditions and limitations imposed on therapy provided outside the home. See the *Short-term rehabilitation services and Habilitation therapy services* sections and the schedule of benefits.

Home health care services do not include **custodial care**.

Hospice care

Eligible health 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**
- Bereavement counseling
- Respite care

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

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

Skilled nursing facility

Eligible health services include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

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

Emergency services and urgent care

Eligible health services include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

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 you in a **hospital** emergency facility or comparable facility, necessary to determine if an **emergency medical condition** exists
- Treatment to stabilize your condition
- Care in an emergency 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

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**. Except for care received from an **out-of-network provider** when a **network provider** is not reasonably available and **emergency services** for an **emergency medical condition**, services and supplies obtained from **out-of-network providers** are not covered under the plan. When you are treated by an **out-of-network provider** when a **network provider** is not reasonably available or for an **emergency medical condition**, we will reimburse the **out-of-network provider** at the usual and customary charge. Please contact Member Services if you receive a bill from the **out-of-network provider**. We will work to resolve the outstanding balance so that all you pay is the appropriate **network deductible**, **coinsurance**, or **copayments** under your plan.

You will be credited for:

- Any amounts due to you that would have been paid if the **provider** were a **network provider**
- Any out-of-pocket amounts that you paid to the **provider**, in excess of the allowed amount. Such amounts will be credited to your **calendar year deductible** amount and plan **coinsurance** limits, as applicable.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Texas Health + Aetna Health** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care.

If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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 assistance. If possible, call your **physician or PCP** but only if a delay will not harm your health.

Non-emergency condition

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 and the *exception- Emergency services and urgent care and Preauthorization covered benefit reduction* sections for specific plan details.

In case of an urgent condition

Urgent condition within the service area

If you need care for an **urgent condition** while within the **service area**, you should first seek care through your, **physician.** If your **physician** is not reasonably available to provide services, you may access urgent care from an **urgent care facility** 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**.

Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition,** the plan may not cover your expenses. See the *exception –Emergency services and urgent care* section and the schedule of benefits for specific plan details

Specific conditions

Autism spectrum disorder

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

Eligible health 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 only 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
- Occupational therapy
- Physical therapy
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder

Important note:
Applied behavior analysis requires **preauthorization** by **Texas Health + Aetna Health**. The **network provider** is responsible for obtaining **preauthorization**. You are responsible for obtaining **preauthorization** if you are using an **out-of-network provider**.

Birthing center

Eligible health services include prenatal and postpartum care and obstetrical services from your **provider.** After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

These time frames apply if your child is born without any problems. 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**.

Diabetic equipment, supplies and education

Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin and insulin analog preparations
  - 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 and tablets
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Non-prescription medications for the purpose of controlling blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
  - Biohazard disposal containers
- Equipment
  - External and implantable insulin pumps and pump supplies
    - 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 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.

Eligible health 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**

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Family planning services – other

Eligible health services include certain family planning services provided by your **physician** such as:

- Voluntary sterilization for males

Jaw joint disorder treatment

Eligible health services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

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

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a health care facility after a vaginal delivery
- 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 you and your **physician** agree to a shorter **stay**, you and your newborn will receive timely post-delivery care. A **physician**, registered nurse, or other licensed health care **provider** can provide the post-delivery care. You can choose to get the post-delivery care in:

- Your home
- A health care **provider's** office
- A health care facility
- Another location determined to be appropriate under applicable Texas law

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

Coverage also includes the services and supplies needed for circumcision by a **provider**.

Pregnancy complications

Eligible health services include services and supplies from your **provider** for pregnancy complications.

Pregnancy complications means problems caused by pregnancy that pose a significant threat to the health of the mother or baby, including:

- Hyperemesis gravidarum (pernicious vomiting of pregnancy), toxemia with convulsions, severe bleeding before delivery due to premature separation of the placenta from any cause, bleeding after delivery severe enough to need a transfusion or blood
- Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.
- Amniotic fluid tests, analyses, or intra-uterine fetal transfusion made for Rh incompatibility
- An emergency medical cesarean section due to pregnancy complications
- Miscarriage if not elective or therapeutic
- Termination of ectopic pregnancy

The plan does not cover a scheduled or non-emergency cesarean delivery under the pregnancy complications benefit.

We will cover pregnancy complications the same as we would for any other **illness** or **injury**.

Mental health treatment

Eligible health services include the treatment of **mental 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 related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital, crisis stabilization unit** 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** and **telehealth** consultation.
  - Individual, group and family therapies for the treatment of mental health
  - 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**, or needing to receive the same services outside your home.
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease 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**.

Substance abuse related disorders treatment

Eligible health services include the treatment of **substance abuse** 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.** Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

  As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and 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 psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** and **telehealth** consultation).

- Individual, group and family therapies for the treatment of **substance abuse**
    - Other outpatient **substance abuse** treatment such as Outpatient **detoxification**
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
        - You are homebound
        - Your **physician** orders them
        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Treatment of withdrawal symptoms
    - Substance use disorder injectables
    - 23 hour observation

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
    - Treat a fracture, dislocation, or wound.
    - Cut out cysts, tumors, or other diseased tissues.
    - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
    - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:
    - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
    - Other body tissues of the mouth fractured or cut due to **injury.**
- Crowns, dentures, bridges, or in-mouth appliances only for:
    - The first denture or fixed bridgework to replace lost teeth.
    - The first crown needed to repair each damaged tooth.
    - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.
- Accidental **injuries** and other trauma. Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state.
    - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
    - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.
- Removal of tumors and cysts requiring pathological examination.

- Fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.
- Oral **surgery** and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

Reconstructive surgery and supplies

Eligible health 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, **eligible health services** for reconstructive breast **surgery** include:
  - 96 hours of inpatient care following a mastectomy
  - 48 hours of inpatient care in a network health care facility after a 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. This includes an abnormal structure that is caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.
  - The purpose of the **surgery** is to improve function or attempt to create a normal appearance.

Transplant services

Eligible health services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

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**.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the **IOE facility** we designate to perform the transplant you need. You may also get transplant services at a non-**IOE facility**, but your cost share will be higher.

Important note:

- If there is no IOE facility for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an IOE facility in another one of our networks. If you don't get your transplant services at the IOE facility we designate, your cost share will be higher.
- 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 Program® (NME), all medical services must be managed through the NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the eligible health service is not directly related to your transplant.

Treatment of infertility

Basic infertility

Eligible health services include seeing a **network provider:**

- To diagnose 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**.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- 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 outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Diagnostic follow-up care related to newborn hearing screening

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

Cardiovascular disease testing

Eligible health services include certain lab tests for the early detection of cardiovascular disease when you have:

- Diabetes, or
- An intermediate or higher risk of getting coronary heart disease based on the 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

Chemotherapy

Eligible health 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**.

Eligible health services also include oral 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 medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost-sharing for anti-cancer **prescription drugs** will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. 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.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in the office
- A home care **provider** in your home

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Plan Benefit secure member website at www.texashealthaetna.com. or calling the number on the back of your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this certificate.

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

Outpatient radiation therapy

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

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

Specialty prescription drugs

Eligible health services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this booklet-certificate.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your Plan Benefit secure member website at http://www.texashealthaetna.comor calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this certificate.

Certain injected and infused medications may be covered under the outpatient **prescription drug** coverage. You can access the list of **specialty prescription drugs** by contacting Member Services or by logging onto your Plan Benefit secure member website at http://www.texashealthaetna.comor calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this certificate.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health 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

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage 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.
Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure.**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**, or
  - 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:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury** or **surgical procedure**, except as described in the Speech or hearing loss of impairment section or
  - 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 and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Inpatient and outpatient treatment for acquired brain injury

Eligible health 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
- Psychosocial 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

Eligible health 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.

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

- Within the scope of their license, and

Within the scope of the services provided under and accredited rehabilitation program for brain injury

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Habilitation therapy services

Habilitation therapy services are services that 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).

Eligible health services include habilitation therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**
- Other provider acting within the scope of their license

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your ability to perform activities of daily living on your own.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development

Other services

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Alzheimer's disease

Eligible health 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 service

Eligible health services include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

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 travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services** you need, and
  - The two conditions above are met.

Clinical trial therapies (experimental or investigational)

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or **terminal illnesses** and all of the following conditions are 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 that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- 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. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an institutional review board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred to you by 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 those terms are 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 of 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 trial that is exempt from having such an investigational new drug application

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

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. We list examples of those in the E*xceptions* section.

Hearing aid exams

Eligible health services include hearing care that includes hearing aid exams as described below.

Hearing aid exams are:

- Audiometric hearing exam 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, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
  - Any other **provider** acting within the scope of their license

Hearing aids and cochlear implants and related services

Eligible health 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

Non-routine/non-preventive care hearing exams

Eligible health services for adults and children include charges for an audiometric hearing exam for evaluation and treatment of **illness**, **injury** or hearing loss, if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Nutritional supplements

Eligible health services include formula and low protein modified food products ordered by a **physician** for the treatment or diagnosis 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.

Eligible health services are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician.**

Orthotic devices

Eligible health services include the initial orthotic device and subsequent replacement that your **physician** orders and administers.

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs. 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 unless you misuse or lose the device. Examples include:
  - 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

Osteoporosis

Eligible health services include the diagnosis, treatment and management of osteoporosis by a **physician**. The services include Food and Drug Administration approved technologies, including bone mass measurement.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

We will cover the same type of devices that are covered by Medicare. Your **provider** will tell us which device best fits your needs.

Prosthetic device means:

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

Coverage includes:

- Repairing or replacing the original device unless you misuse or lose the device. Examples include:
  - 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

Vision care

Eligible health services include a routine vision exam provided by an ophthalmologist, optometrist, or any other **provider** acting within the scope of their license. The exam will include refraction and glaucoma testing.

Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan

Read this section carefully so that you know:

- How to access **network pharmacies**
- **Eligible health services** under your plan
- What outpatient **prescription drugs** are covered
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **preauthorization** requirements apply
- How do I request a medical exception
- What your plan doesn't cover – some **eligible health service** exceptions
- How you share the cost of your outpatient **prescription drugs**

Some **prescription drug**s may not be covered or coverage may be limited. This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

How to access network pharmacies

How do you find a network pharmacy?

You can find a network pharmacy in two ways:

- **Online:** By logging onto your secure member website at www.texashealthaetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any of the **network pharmacies**. **Pharmacies** include **network retail**, **mail order** and **specialty pharmacies**.

What if the pharmacy you have been using leaves the network?

Sometimes a **pharmacy** might leave the network. If this happens, you will have to get your **prescriptions** filled at another **network pharmacy**. You can use your provider **directory** or call the toll-free Member Services number on your member ID card to find another **network pharmacy** in your area.

Eligible health services under your plan

What does your outpatient prescription drug plan cover?

Any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover - some eligible health service exceptions* section.
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan's general rules:

- You need a **prescription** from your **prescriber.**
- Your drug needs to be **medically necessary** for your **illness** or **injury.** See the *Medical necessity and preauthorization* requirements section.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Your outpatient **prescription drug** plan includes drugs listed in the **drug guide. Prescription drugs** listed on the **formulary exclusions list** are excluded unless a medical exception is approved by us prior to the drug being picked up at the pharmacy. If it is **medically necessary** for you to use a **prescription drug** on the **formulary exclusions list**, you or your **prescriber** must request a medical exception. See the *How do I request a medical exception?* section.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

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.

What outpatient prescription drugs are covered

Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy**
- Calling or e-mailing a **network pharmacy** to order the medication
- Submitting your **prescription** electronically

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at a **network, retail**, **mail order** or **specialty pharmacy.**

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 90 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. 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 you bought it without using your plan or any other **prescription drug** benefits or discounts.

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Mail order pharmacy

Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Specialty pharmacy

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Each **prescription** is limited to a maximum 30 day supply. You can access the list of **specialty care prescription drugs** by logging onto your secure member website at www.texashealthaetna.com or calling the number on your ID card.

Specialty prescription drugs are covered when dispensed through a network **specialty pharmacy** or network **retail pharmacy**.

Specialty prescription drugs may fall under various drug tiers regardless of their names.

Other services

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 date a 90-day supply is dispensed

Preventive contraceptives

Your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your secure member website at www.texashealthaetna.com or calling the number on your ID card.

We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug or device** is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

Important note: You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

Diabetic supplies

Eligible health services include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine monitoring and/or visual reading
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Insulin and insulin analogs
- Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits

See your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.

Nutritional supplements

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

Eligible health services are covered to the same extent that the plan covers drugs that are available only on the orders of a **physician**.

Off-label use
U.S. Food and Drug Administration (FDA) approved **prescription drugs** and health care services related to the administration of these **prescription drugs** may be covered when the off-label use of the drug has been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition(s) by a prescription drug compendium
- Substantially accepted peer-reviewed medical literature
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **preauthorization**, **step therapy** or other requirements or limitations.

Orally administered anti-cancer drugs, including chemotherapy drugs
Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer medications covered as a medical benefit rather than as a **prescription drug** benefit. Also, the cost sharing for anti-cancer **prescription drugs** will not exceed the **coinsurance** or **copayment** applicable to a chemotherapy visit or cancer treatment visit. 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.

Over-the-counter drugs
Eligible health services include certain over-the-counter medications, as determined by the plan. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto your secure member website at www.texashealthaetna.com.

Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs
Eligible health services include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Tobacco cessation prescription and over-the-counter drugs
Eligible health services include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

How you get an emergency prescription filled

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

Type of pharmacy	Your cost share
Network pharmacy	• You pay the **copayment**.
Out-of-network pharmacy	• You pay the **pharmacy** directly for the cost of the **prescription**. Then you fill out and send a **prescription drug** refund form to us, including all itemized **pharmacy** receipts. • Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your **prescription** less your **copayment/coinsurance.**

Where your schedule of benefits fits in

You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your **prescription drug** costs are based on:

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

The plan may, in certain circumstances, make some **brand-name prescription drugs** available to you at the **generic prescription drug copayment** level.

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for each **prescription** fill or refill. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **prescription** fill or refill. 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 you bought it without using your plan or any other **prescription drug** benefits or discounts.

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

What preauthorization requirements apply

For certain drugs, you, your **prescriber** or your pharmacist 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 preauthorized drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the toll-free number on your member ID card or log on to your secure member website at www.texashealthaetna.com.

There is another type of **preauthorization** for **prescription drugs**, and that is **step therapy**. **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 the **step therapy prescription drugs** on the **preferred drug guide.** For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your secure member website at www.texashealthaetna.com.

How do I request a medical exception?

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for which health care services are denied through **preauthorization** or **step therapy.** You, someone who represents you or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case-by-case decision, and will not apply to other members. If approved by us, you will receive the preferred drug or non-preferred drug benefit level.

You, someone who represents you or your **prescriber** may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification 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 determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision.

Prescribing units

Some outpatient **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your outpatient **prescription drug** is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Some outpatient **prescription drugs** are limited to 100 units dispensed per **prescription** order or refill.

Any outpatient **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

What your plan doesn't cover – some eligible health service exceptions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exceptions (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exception (exclusion).

In this section we tell you about the exceptions. We've grouped them to make it easier for you to find what you want.

- Under "General exceptions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exceptions, in "Exceptions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exceptions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exceptions

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

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.
- For allogenic and autologous blood donations, only administration and processing expenses are covered.

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

Custodial care
Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a 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/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.
Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts

Early intensive behavioral interventions
Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services
Examples of those services are:

- Any service or supply for education, training or retraining services or testing.
- Special education, remedial education, wilderness treatment program, job training and job hardening programs

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or 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 trial therapies (experimental or investigational) or covered under Clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities, except if you have an acquired brain injury. See the *Specific therapies and tests* section
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

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

- Non-surgical treatment of **jaw joint disorder** (TMJ)

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 under the *Eligible health services under your plan – Habilitation therapy service*s section and under the *Eligible health services under your plan – Services for children with developmental delays* section.

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 are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes

- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Orthotic devices

- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Other primary payer

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

Outpatient prescription or non-**prescription drugs** and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the policyholder or through a third party vendor contract with the policyholder.

Personal care, comfort or convenience items

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

Pregnancy charges

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section.

Routine exams

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section.

Services provided by a family member

- Services provided by a spouse, parent, child, step-child, brother, sister, in-law or any household member, except when that family member is a dentist who is licensed in the State of Texas to provide the service rendered.

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 booklet-certificate.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, 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 or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Except when used to treat an **illness** or **injury**, services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
    - Strength
    - Physical condition
    - Endurance
    - Physical performance

Telemedicine and telehealth

- Services given by **providers** that are not contracted with **Texas Health + Aetna** as **telemedicine** or **telehealth providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
    - 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 as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF).This also includes:
    - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
    - Hypnosis and other therapies
    - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
    - Nicotine patches
    - Gum

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, except to the extent coverage is required by applicable laws

Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be 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.

Additional exceptions for specific types of care

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under a **physician's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services—contraceptives

- Services and supplies provided for an abortion (except as described in the *Pregnancy complications* section and except when the pregnancy places the woman's life in serious danger or poses a serious risk of substantial impairment of a major bodily function)
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

Physicians and other health professionals

There are no additional exceptions specific to **physicians** and other **health professionals**.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital (Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- 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

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

Outpatient private duty nursing

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Specific conditions

Family planning services - other

- Services and supplies provided for an abortion [except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related newborn care

- 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

- Mental health 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 *Eligible health services under your plan – Preventive care and wellness* 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

Obesity (bariatric) surgery

- 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 *Eligible health services under your plan – Preventive care and wellness* 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

Oral and maxillofacial treatment (mouth, jaws and teeth)

- Dental implants

Transplant 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**

Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - 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.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers and any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

Specific therapies and tests

Acupuncture

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

Other services

Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Texas Health + Aetna Health's** claim policies).

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Hearing aid exams

The following services or supplies:

- Hearing aids

- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
    - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
    - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services and Outpatient prescription drug* section.

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if 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

Vision care

Adult vision care

- 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

Vision care services and supplies

Your plan does not cover vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-**prescription** sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes.

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

- Including compounded bioidentical hormones

Devices, products and appliances, except those that are specially covered

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Texas Health + Aetna Health's** Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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
- That are used for the purpose of weight gain or reduction, 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 (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunizations related to travel or work

See the *Preventive care immunizations* section for covered immunizations.

Immunization or immunological agents except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan –Outpatient prescription drugs* section.

Infertility

- **Prescription drugs** used primarily for the treatment of **infertility**.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us. See the *Eligible health services under your policy – Diabetic equipment, supplies and education* section for covered equipment and supplies.
- Needles and syringes, except for those used for self-administration of an injectable drug
- 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

Prescription drugs:

- Dispensed by other than a **network retail**, **mail order** and **specialty pharmacies** except as specifically provided in the What prescription drugs are covered section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the How to get an emergency prescription filled section.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.

- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- 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 would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written.

Replacement of lost or stolen prescriptions

Smoking cessation

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

Test agents except diabetic test agents

We reserve the right to exclude:

- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network providers**.

Network providers

We have contracted with **providers** in the **service area** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- Urgent care – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section.
- Transplants – see the description of transplant services in the *Eligible health services under your plan – specific conditions* section.
- **Network provider** not reasonably available – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. Your **network provider** requests access to the **out-of-network provider** in advance and we agree. We will let you know our decision as quickly as appropriate for the circumstance, but no later than five business days after we receive your request. Contact Member Services at the toll-free number on your ID card for assistance.

> **Important note:**
> If we agree to your request to see an **out-of-network provider**, you may receive a bill for services from the **out-of-network provider**, as we paid them at the usual and customary rate. We will work with the **provider** so that all you pay is your appropriate network level cost-sharing.

You may select a **network provider** from the **directory** through your secure member website at www.texashealthaetna.com. You can search our online **directory**, DocFind®, for names and locations of **providers**.

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

Your PCP

We encourage you to access **eligible health services** through a **PCP**. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

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

How do you choose your PCP?
You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section.

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

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

Your **PCP** can also:
- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

How do I change my PCP?
You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your Plan Benefit secure member website at www.texashealthaetna.com to make a change.

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 a member of **Texas Health + Aetna Health** 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 are a new enrollee and your provider is an out-of-network provider	**If you are a current enrollee and your provider stops participation with Texas Health + Aetna Health**
Request for approval	You need to complete a transition coverage request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, 90 days. This date is based on the date the **provider** terminated their participation with us.

	If you have a terminal illness and your provider stops participation with Texas Health + Aetna Health
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the number on your ID card for information on continuity of 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 **Texas Health + Aetna Health**.
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 and your provider stops participation with Texas Health + Aetna Health
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the 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.

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

What the plan pays and what you pay

Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **copayments/coinsurance**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

  And then

- The plan and you share the expense. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment**/**coinsurance**.

  And then

- The plan pays the entire expense after you reach any **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity and preauthorization requirements* section.

- When your plan requires **preauthorization**, your **physician** requested it, we refused it, and you get an **eligible health service** without **preauthorization**. See the *Medical necessity and preauthorization requirements* section.

- Usually, when you get an **eligible health service** from someone who is not a **Texas Health + Aetna Health provider**. See the *Who provides the care* section.

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 towards your **maximum out-of-pocket limit**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works
Your **deductible** is the amount you need to pay, after paying your **copayment** or **coinsurance**, for **eligible health services** per Calendar Year as listed in the schedule of benefits. Your **copayment** or **coinsurance** does not count toward your **deductible**.

How your copayment/ coinsurance works

Your **copayment/coinsurance** is the amount you pay for **eligible health services** after you have paid your **deductible**. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/coinsurance** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/coinsurance** up to the **maximum out-of-pocket limit** for your plan. Your 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 benefits** for the remainder of that **Calendar Year**.

Important note:
See the schedule of benefits for any **deductibles**, **copayments/ coinsurance**, **maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible health services**.

When a claim comes in, we decide and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the policyholder not later than 20 days after the date of loss. • The claim form will provide instructions on how to complete and where to send the form(s).	• We must send you a claim form within 15 business days of your request. • If the claim form is not sent on or by the 16th day, you are considered to have complied with the requirements for submitting proof of loss. • You may send us: - A description of services - Itemized bill of charges - Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us.	• No later than 90 days after you have incurred expenses for **covered benefits**. • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

Notice	Requirement	Deadline
Benefit payment	• Written proof must be provided for all benefits. • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss.	• We will accept or reject a claim not later than 15 business days of receiving all items, statements and forms. • Benefits will be paid not later than 5 business days after the date the notice of acceptance is sent. • If we reject the claim the written notice will include the reason for denial. • All benefits payable will be paid no later than 60 calendar days from the date proof of loss is received.

Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim

An urgent care 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.

If you are pregnant, an urgent care 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 ask 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 decision

You or your **provider** may ask for a concurrent care claim extension to request more services. We will tell you when we make the decision 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 the concurrent care claim extension period, you are still responsible for your share of the costs, such as **copayments**/**coinsurance** and **deductibles** that apply to the service or supply. If your request for extended services is not approved after your adverse determination appeal, and we support 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 how much time we have to tell you about our decision on a **preauthorization** request, a concurrent care authorization request and a retrospective review.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

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)	No later than 24 hours after we receive the request, followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
If you are not hospitalized	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
If you are currently receiving prescription drugs or intravenous infusions	No later than the 30th day before the date on which the prescription drugs or intravenous infusions will be discontinued	Not applicable	Not applicable	Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for a life-threatening condition	No later than one (1) hour after we receive the request	Not applicable	Not applicable	Not applicable
Requests for step therapy exception (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 the request	Not applicable	Not applicable	Not applicable

Acquired brain injury	No later than 3 business days after we receive the request	Not applicable	Not applicable	Not applicable
Retrospective review	30 days	15 days	30 days	45 days

*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.

Adverse determinations

We pay many claims at the full rate **negotiated charge** with a **network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an "adverse determination. It is also an "adverse determination" if we rescind your coverage entirely.

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

- The main reason for the denial
- The clinical basis for the 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 policy
  - Requests for step therapy exception

The chart below tells you 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 intravenous infusions that you are currently receiving	Retrospective review
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 three 3 business days to you and your provider	Within 3 business days to you and your provider	No later than the 30th day before the date 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 you no later than the times shown in the chart above.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card, or write Member Services. Your complaint should include a description of the issue. Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process
- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But 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 determinations* 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.

We will review the information and provide you with 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.

If your complaint concerns an emergency, or denial of continued hospitalization, we will do an expedited appeal review. See the *Appeal of adverse determinations* 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 complaint* and *Appeal of adverse determinations* sections below explain the appeal processes for both types of appeals.

Appeal of a complaint

You can ask us to re-review your complaint. You can appeal to us verbally or in writing.

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 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 members.
- **Texas Health + Aetna Health** representatives who were not involved in making the initial decision.
- **Providers** (including **specialists**) who were not involved in the initial 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 **physicians** or **providers** consulted during the review
- The name and affiliation of all **Texas Health + Aetna Health** 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.

Appeals of adverse determinations

You can appeal our adverse determination. We will assign your appeal to someone who was not involved in making the original decision.

You can appeal by sending a written appeal to the address on the notice of adverse determination, or by calling the toll-free number on your ID card. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse determination
- Your reasons for making the appeal
- Any other information you would like us to consider
- If you appealed verbally or by phone, we will send you a one page appeal form to be filled out by you or your authorized representative.

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 that you are allowing someone to appeal for you. You can get this form on our website or by calling the toll-free number on your ID card. 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 determination.

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.

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

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

Timeframes for deciding appeals of adverse determinations

The amount of time that we have to tell you about our decision on an appeal of an adverse determination 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 verbally or in writing. If we tell you verbally, we will also send you a letter within 3 calendar days after the verbal notice.

Type of claim	**Our response time**
Urgent care claim	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received
Emergency medical condition	As soon as possible (based on the medical urgency of the case) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

Type of claim	**Our response time**
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 from date all information to complete the review is received*
If you are receiving **prescription drugs** or intravenous infusions	As soon as possible, but no later than 1 business day from date all information to complete the review is received
Pre-service claim requiring **preauthorization**	As soon as possible but no later than 15 calendar days*
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 days after the request
Retrospective claim	As soon as possible, but no later than 30 calendar days from receipt of the request for appeal*
Expedited internal appeal	As soon as possible (based on the medical or dental immediacy of the condition, procedure, or treatment under review) but no later than 1 business day or 72 hours (whichever is less) from the date all information to complete the review is received

*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 not 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 appeals process

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

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

You do not have to complete the internal appeal process when:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the independent review process.
- 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 internal review process.
- 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 **Texas Health + Aetna Health**.

You have a right to independent review only if:

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

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 Review by an Independent Review Organization (IRO) form.

You must submit the Request for Review by an Independent Review Organization (IRO) Form:

- To **Texas Health + Aetna Health**
- And you must include a copy of the notice from us and all 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.

Texas Health + Aetna Health 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 the 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.

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, or
  - Be much less effective if not started right away (in the case of **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.

Coordination of benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). "Plan" is defined below in the *Key terms* section.

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 terms will help you understand this *COB* section.

<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>• It includes:</td><td>• 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 policies
• 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 policies
• Medicare or other governmental benefits, as permitted by law</td></tr>
</table>

<table>
<tr><td>• It does not include:</td><td>• 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
• Accident only coverage
• Specified accident coverage
• School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "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</td></tr>
<tr><td colspan="2">• 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.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>• How this plan coordinates with like benefits:</td><td>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.</td></tr>
</table>

• The order of benefit determination rules for this plan:	The order of benefit determination rules determine 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 and 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**, **coinsurance** 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 accordance 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 a 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 than the primary plan's payment arrangement and if the health care **provider's** or **physician's** 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 **deductible**, **copayment**, or **coinsurance** 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	

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 that 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 a 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:
    - Major medical coverages that are superimposed over base plan hospital and surgical benefits
    - Insurance type coverages that are written in connection with a closed panel plan 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 a 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 contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as 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 that secondary plan.

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

If you are covered as a:	Primary plan	Secondary plan
Non-dependent or dependent	The plan covering you as an employee, policyholder, subscriber, or retired employee	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed so that the plan covering you or your spouse as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee. If you have any questions about this you can contact us: • **Online:** Log on to your member website at www.texashealthaetna.com. Select Find a Form, then select Your Other Health Plans. • **By phone:** Call the toll-free number on your ID card.	
COB rules for dependent children Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply.		
Child of: • Parents who are married or living together, whether or not they have ever been married	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse's plan is primary	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.

If you are covered as a:	Primary plan	Secondary plan
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination: See *Child of* content above.	
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.	
Child of: Parents, who is also covered under a spouse's plan	The plan that has covered the person longer is primary. If 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	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).

If you are covered as a:	Primary plan	Secondary plan
COBRA or state continuation This rule does not apply if: • The other plan 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	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally. This plan will not pay more than it would have paid had it been the primary plan.	

Effect on the benefits of this plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan:
  - Will calculate the benefits it would have paid in the absence of other health care coverage. The calculated amount will be applied to any allowable expense under its plan that is unpaid by the primary plan.
  - May reduce its payment so that the total benefits paid or provided by all plans for the claim equal 100% of the total allowable expense for that claim.
  - Must credit to its plan **deductible** any amounts it would have credited to its **deductible** in the absence of other health care coverage.
- If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel **provider**, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

Compliance with federal and state laws concerning confidential information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits.

Facility of payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid. Or, we may recover from any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of the benefits provided in the form of services.

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.

- **Online:** Log on to your member website at www.texashealthaetna.com. Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free number on your ID card.

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 above

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not make any required **premium** contributions
- 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 coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness**, **injury**, sabbatical or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence
Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage will stop on the date that your employment ends
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your plan coverage ends* section.
Your employment ends because of a paid or unpaid medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence

Your employment ends because of a leave of absence that is not a medical leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 1 months from the start of the absence
Your employment ends because of a military leave of absence.	If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below: • Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence

It is your policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- You do not make the required **premium** contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed above, other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plan that we offer.
- Your dependent has exhausted the maximum benefit under your medical plan

Important note:
Your employer will notify Texas Health + Allina Health 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 us 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 we receive 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 plan coverage ends* section for more information.

Why would we end your and your dependents' coverage?

We may immediately end your coverage if you commit fraud or intentionally misrepresent a material fact when you applied for or obtained coverage. You can refer to the *General provisions-other things you should know - Honest mistakes and intentional deception* section for more information on rescissions.

On the date your coverage ends, we will refund to the policyholder any prepayments 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 because you used your rights under the *When you disagree – claim decisions and appeals procedures* section of this booklet-certificate.

When will we send you a notice of your coverage ending?

The policyholder will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described in the *Why would we end your coverage?* section above).

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group policy terminates or at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, who is eligible for continuation and how long coverage can be continued.

Qualifying event causing loss of coverage	**Covered persons eligible for continued coverage**	**Length of continued coverage (starts from the day you lose current coverage)**
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former policyholder files for bankruptcy	You and your dependents	18 months

When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

Employer/group health plan notification requirements		
Notice	**Requirement**	**Deadline**
General notice – policyholder or **Texas Health + Aetna Health**	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	Your active employment ends for reasons other than gross misconduct Your working hours are reduced You become entitled to benefits under Medicare You die You are a retiree eligible for retiree health coverage and your former policyholder files for bankruptcy	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – policyholder or **Texas Health + Aetna Health**	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA **–** policyholder or **Texas Health + Aetna Health**	Notify you and your dependents if you are not entitled to COBRA coverage	Within 14 days after notice of the qualifying event
Termination notice **–** policyholder or **Texas Health + Aetna Health**	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify the policyholder if: • You divorce and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the policyholder if: • The Social Security Administration determines that you or a covered dependent qualify for disability status	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the policyholder if: • The Social Security Administration decides that the beneficiary is no longer disabled	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the policyholder if: • You are electing COBRA	60 days from the qualifying event. You will lose your right to elect, if you do not: • Respond within the 60 days • And send back your application

How can you extend the length of your COBRA coverage?
The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce and are no longer responsible for dependent coverage • You become entitled to benefits under Medicare • Your covered dependent children no longer qualify as dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?
You enroll by sending in an application and paying the premium. The policyholder has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the premium. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?
Your first premium payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the policyholder within 31 days of their eligibility.
- You pay the additional required **premiums**.

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the preexisting conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

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	• Dependent who has been covered under the plan for at least 1 year • An infant under 1 year of age	3 years
• Retirement of employee		
• Divorce		

When do I receive state continuation information?
The chart below lists who must give the 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 • The amount of premium to be charged (in the case of the employee's death or retirement)	Immediately 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 within 60 days 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 policyholder

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 the 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 or could be covered under Medicare
- The date you are covered for similar benefits by another health insurance policy or program
- The date your are covered for similar benefits , whether covered or not covered for those benefits by any arrangement of coverage
- 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 call the toll-free Member Services number on your ID card.

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

Your coverage may be extended if you or your dependents are totally disabled when coverage ends.

You are "totally disabled" if you cannot perform all of the substantial and material duties and functions of your own occupation and any other gainful occupation in which you earn substantially the same compensation you earned before the disability.

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

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

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

How can you extend coverage for hearing services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

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

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled 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 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year. 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 can you extend coverage for a child in college on medical leave?

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

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

To extend coverage the leave of absence must:

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

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

General provisions - other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate
We prepared this booklet-certificate according to ERISA, and according to other federal laws and state laws that apply. You and we will interpret it according to these laws.

How we administer this plan
We apply policies and procedures we've develop 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 accident and health insurance policy. This document may have amendments too. Under certain circumstances, we or the policyholder or the law may change your plan at the time of renewal and only in accordance with the **group policy**. 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 **Texas Health + Aetna Health** may waive a requirement of your plan. No other person – including the policyholder or **provider** – can do this.

If a service cannot be provided to you
Sometimes things happen that are 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 you or the policyholder 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 *When you disagree - claim decisions and appeal procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

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

Physical examinations and evaluations
At our expense, we have the right to have a **physician** of our choice examine you. This will be done at all 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.

Things that would be important to keep are:
- Names of **physicians**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years after the booklet-certificate effective date.

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. This is called rescission.
- 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 advanced written notice of any rescission of coverage.
- You have the right to a **Texas Health + Aetna Health** appeal.
- You have the right to a third party review conducted by an independent external review organization.

We won't rescind your coverage due to an intentional deception if the deception happened more than 2 years after the booklet-certificate effective date.

In the absence of fraud, any statement made is considered a representation and not a warranty. We will only use a statement during a dispute if it is shared with you and your beneficiary, or the person making the claim.

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. If you assign benefits to such a provider, we will pay them directly.

Notice of claim
We must receive your claim within 20 days (or as soon as reasonably possible) after you get a covered medical service. You can send the claim to us or to one of our authorized agents. We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. See the *Proof of loss* section below.

Proof of loss
We must receive written proof of loss from you within 90 days after your loss occurs. If you couldn't reasonably provide this proof within 90 days, we will still accept your claim. But you must provide the proof as soon as possible, but no later than one year after the 90 days ends (unless you were legally incapacitated).

Time of payment of claims
We will pay benefits to you or your assignee. After we receive your timely proof of loss, we will pay claims within 60 days after we receive the proof of loss. Please see the *Proof of loss* section above for more information.

Financial sanctions exclusions
If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health 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 http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Grace period
A grace period of 45 days after the **premium** due date will be allowed for the payment of each **premium**.

Premium contribution
This plan requires the policyholder to make **premium** payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** payments are not made by the end of the grace period. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums
The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Recovery of overpayments
We sometimes pay too much for **eligible health 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, then, 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 **injuries.**
- You are giving us a 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 **injuries** 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 payout, or within 5 days of when you receive the money. Notify us by calling Member Services at the toll-free number on your member ID card.

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 lessor 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

Important note:
If a declaratory judgment action is brought, the court may not award costs or attorney's fees to any party in the action.

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 plan 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

Payment to a conservator, other than you

Sometimes a court order gives another person certain rights and duties to act on behalf of your dependent child. Such a person is called a managing or possessory conservator. We may pay that person benefits on behalf of your dependent child. To receive benefits, they must send us a written certified copy of the court order with the claim form. But they are not entitled to benefits if:

- We received a valid assignment of benefits on an unpaid medical bill
- You sent us a claim for benefits for an **eligible health service** that you paid

Reimbursement to Texas Department of Human Services

We will repay the actual costs of medical expenses the Texas Department of Human Services pays through medical assistance for you or your dependent if you or your dependent are entitled to payment for the medical expenses.

Repayment of these medical expenses for your dependent child will be paid to the Texas Department of Human Services if, when you submit proof of loss, you notify us in writing that:

- Your dependent child is covered under the financial and medical assistance service program in Texas and you either:
  - Have possession or access to the child through a court order; or
  - Are not entitled to possession of or access to the child and are required by the court to pay child support

You will need to ask us to make direct payment to the Texas Department of Human Services.

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 providers' claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card.

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

Effect of benefits under other plans

Effect of a Health Maintenance Organization plan (an HMO Plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

If you and your covered dependents:	Change of coverage:	Coverage takes effect:
Live in an HMO plan enrollment area	During an open enrollment period	Group policy anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

Extension of benefits for pregnancy

If you are:	Evidence you must provide:	Extension:	Extension will end the earlier of:
In a hospital not affiliated with the HMO plan	The HMO plan provides an extension of benefits for pregnancy	Same length of time and for the same conditions as the HMO plan provides	• The end of a 90 day period, or • The date the person is not confined

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

Effect of prior coverage - transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part of or this entire plan.
- The plan must have been sponsored by the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan See the *General coverage provisions* section of the schedule of benefits.

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a **medically necessary** leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

Glossary

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

Body mass index (BMI)
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Coinsurance
The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

Copay/Copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance, except as covered in the *Reconstructive surgery and supplies* section.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary.**
2. You received **preauthorization**, if required.

Crisis stabilization unit
An institution licensed or certified by the Texas Department of Mental Health and Mental Retardation to provide a 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 and structured care.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it is prescribed by a **physician** or given by trained medical personnel.

Deductible
The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can 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.

Directory
The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at http://www.texashealthaetna.com under the Provider search label. When searching Provider search, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain **Texas Health + Aetna Health** plans.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **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

Effective date of coverage
The date your and your dependents' coverage begins under this booklet-certificate as noted in **Texas Health + Aetna Health's** records.

Eligible health services
The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *exceptions* section or in the schedule of benefits**.**

Emergency admission
An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services.**

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious 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 for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition.**

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental or investigational** because:

- 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

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. 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.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any amendments to the **group policy,** booklet-certificate and the schedule of benefits

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, nurses, and physical therapists.

Home health care agency
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital**.

Hospice care
Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

Hospital
An institution licensed as a **hospital** by applicable state and federal laws.

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

Illness
Poor health resulting from disease of the body or mind.

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

Injury

Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility

A facility designated by **Texas Health + Aetna Health** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

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, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

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 amount for payment of **copayments** and coinsurance including any **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health 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.

Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

For health coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

*For **prescription drug** services from a **network pharmacy**:*
The amount we have established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network pharmacy

A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that has contracted with **Texas Health + Aetna Health**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Network provider

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

Non-preferred drug

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

Out-of-network provider

A **provider** who is not a **network provider** or National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan**.**

Partial hospitalization treatment

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

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

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

Pharmacy

An establishment where **prescription drugs** are legally dispensed. This includes a **network retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Preauthorization, preauthorize
A requirement that you or your **physician** contact Texas Health + Aetna Health before you receive coverage for certain 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**.

Preferred drug guide
A list of **prescription drugs** and devices established by **Texas Health + Aetna Health** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Texas Health + Aetna Health** or an affiliate only upon renewal and with 60 days' notice to you. A copy of the **preferred drug guide** is available at your request. Or you can find it on the **Texas Health + Aetna Health** website at www.texashealthaetna.com.

Preferred network pharmacy
A **network retail pharmacy** that **Texas Health + Aetna Health** has identified as a **preferred network pharmacy**.

Premium
The amount you or the policyholder is required to pay to **Texas Health + Aetna Health** to continue coverage.

Prescriber
Any **provider** acting within the scope of their license, who has the legal authority to write an order for outpatient **prescription drugs**.

Prescription
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

Prescription drug
An FDA approved drug or biological which can only be dispensed by **prescription.**

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

- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician, OB, GYN, or OB/GYN
- Maintains continuity of patient care
- Is shown on **Texas Health + Aetna Health's** records as your **PCP**

Provider(s)
A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

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

Psychiatrist
A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

R.N.
A registered nurse.

Residential treatment facility (mental disorders)
- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Texas Health + Aetna Health** 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 per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

Residential treatment facility (substance abuse)
- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by **Texas Health + Aetna Health** or 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 chemical dependence 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**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

In addition to the above requirements, for chemical dependence **detoxification** programs within a residential setting:

- An **R.N.** must be onsite 24 hours per day for 7 days a 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, **Texas Health + Aetna Health** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service area

The geographic area where **network providers** for this plan are located.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

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

Skilled nursing facility does not include institutions that provide only:

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

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

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 access the list of these **specialty prescription drugs** by calling the toll-free number on your ID card or by logging on to your Plan Benefit secure member website at www.texashealthaetna.com.

Specialty pharmacy
This is a **pharmacy** designated by **Texas Health +** Aetna 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** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of **step-therapy** drugs is subject to change by **Texas Health + Aetna Health** or an affiliate only upon renewal and with 60 days' notice to you. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Texas Health + Aetna Health** website at https://www.texashealthaetna.com/individuals-families/find-a-medication.html.

Substance abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a **mental disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures
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, or otherwise physically changing body tissues and organs.

Skilled nursing services
Services provided by an **R.N**. or **L.P.N.** within the scope of their license.

Telehealth
A health service, other than a **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 in the State of Texas, or a **health professional** acting under the delegation and supervision of a **physician** licensed in the State of Texas, and acting within the scope of their license to a patient at a different physical location than the **physician** or **health professional** using telecommunications or information technology

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Texas Health + Aetna Health
Texas Health + Aetna Health Insurance Company, an affiliate, or a third party vendor under contract with **Texas Health + Aetna Health**.

Therapeutic drug class
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**.

Urgent care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition
An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic
A freestanding health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Discount programs

Wellness and other incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services and continue participation as a **Texas Health + Aetna Health** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above.

The award of any such 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. And 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.

Texas Health + Aetna Health Insurance Company

Certificate of coverage amendment

Amendment effective date**:** 07/01/2018

This amendment is part of your certificate of coverage. It is effective on the date shown above and it replaces any other medical amendment you have received before.

The following content is revised in the *When you disagree – claims decisions and appeal procedures* section of your COC:

Independent review

Independent review is a review done by people in an organization outside of **Texas Health + Aetna Health Insurance Company (Texas Health + Aetna Health)**. This is called an independent review organization (IRO).

You have a right to independent review only if:

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

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 **Texas Health + Aetna Health**
- Within 120 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all 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.

Texas Health + Aetna Health 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 the 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.

Jeff Cook
Chief Executive Officer

Texas Health + Aetna Health Insurance Company
(A Stock Company)

Amendment: TX COC Medical
Issue Date: March 8, 2021

Texas Health and Aetna Insurance Company

Amendment

Amendment effective date: January 1, 2021

Your group coverage has changed. This amendment to your booklet and schedule of benefits reflect the changes. It is effective on the date shown above and it replaces any other medical amendment you have received before.

The following content is revised in the *Eligible health services under your plan, Preventive care and wellness* section of your booklet-certificate:

1. Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - 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 these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing for the treatment or diagnosis of a medical condition will not be covered under the preventive care benefit. See the *Specific therapies and tests* section for specific information on diagnostic testing. Except for diagnostic mammograms, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your **Texas Health Aetna** member website at www.texashealthaetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

The following content is revised in the *Eligible health services under your plan, Preventive care and wellness* section of your booklet-certificate:

<table>
<tr><td colspan="2">Routine physical exams for women</td></tr>
<tr><td>

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 breast feeding 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
A gynecological exam that includes a rectovaginal pelvic exam for women who are at risk of ovarian cancer)
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 sections, 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

</td><td>

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 immunodeficiency 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-woman visits to obtain recommended preventive services

</td></tr>
</table>

Eligible health 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.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. Radiological services, lab and other tests given in connection with the exam
- 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 added to or revised in the Eligible health services under your plan - Physicians and other health professionals section of your booklet-certificate:

Alternatives to physician office visits

Walk-in clinic

Eligible health services include, but are not limited to, health care services provided at **walk-in clinics** for:

- Scheduled and unscheduled visits for **illnesses** and **injuries** that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license

The following Important note is removed from the Applied behavior analysis provision within the *Eligible health services under your plan- Specific conditions section* of your booklet-certificate:

Important note:
Applied behavior analysis requires **preauthorization** by **Texas Health|Aetna**. The **network provider** is responsible for obtaining **preauthorization**. You are responsible for obtaining **preauthorization** if you are using an **out-of-network provider**.

The following content is revised in the *Eligible health services under your plan, Specific therapies and tests* section of your certificate:

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Important Note:
Once you have met your **deductible**, your cost share for diagnostic mammograms will be the same as mammograms performed for routine cancer screenings as described in the *Preventive care and wellness* section. Diagnostic mammograms are not subject to any age limitation.

The following language is added within the *Eligible health services under your plan- Specific therapies and tests* section of your booklet-certificate:

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 for the cost shares and maximums that apply to these services.

The following language is revised within the *What preauthorization requirements apply step therapy* provision within the *Eligible health services under your plan- Specific conditions- Outpatient prescription drugs* section of your booklet-certificate:

There is another type of **preauthorization** for **prescription drugs**, and that is **step therapy**. **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. **Step therapy** will not apply to **prescription drugs** used for the treatment of stage-four advanced, metastatic cancer or associated conditions.

You will find the **step therapy prescription drugs** on the **preferred drug guide**. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your **Texas Health Aetna** member website at www.texashealthaetna.com.

The following language is removed from the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Counseling

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

The following language is removed from the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Early intensive behavioral interventions

Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Court-ordered services and supplies

This includes those 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 benefit** under your plan.

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Educational services

Examples of those services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services under your plan – Diabetic equipment, supplies and education.* 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.

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Telemedicine and Telehealth

- Services given by **providers** that are not contracted with **Texas Health Aetna** as **telemedicine** or **telehealth providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - **Telemedicine** or **telehealth** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

The following language is revised in the *What your plan doesn't cover – some eligible health service exceptions* section of your booklet-certificate:

Wilderness treatment programs

See Educational services within this section

The following provision is added to the *What your plan doesn't cover-some eligible health services exceptions-General Exclusions* section of your booklet-certificate.

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 and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

The following language replaces the Mental health treatment exclusion in the *Additional exceptions for specific types of care- Specific conditions* section of your booklet-certificate:

Mental health and substance related 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 *Eligible health services - 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 is removed from the *Additional exceptions for specific types of care- Specific conditions - Treatment of infertility* section of your booklet-certificate:

- Cryopreservation (freezing) of eggs, embryos or sperm.

The following language is added to the Special financial responsibility provision in the What the plan pays and what you pay section of your booklet-certificate:

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. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED."

The following content is revised within the Independent review provision in the *When you disagree-claim decisions and appeal procedures- Independent review* section of your booklet-certificate:

Independent review

Independent review is a review done by people in an organization outside of **Texas Health Aetna**. This is called an independent review organization (IRO).

You have a right to independent review only if:

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

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 **Texas Health Aetna**
- Within 4 months of the date you received the decision from us
- And you must include a copy of the notice from us and all 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.

Texas Health 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 the 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.

The following language is revised in the *Glossary* section of your booklet-certificate:

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).

The following term is revised in the *Glossary* section of your booklet-certificate:

Negotiated charge

For health coverage, this is either:

- The amount a **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third-party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

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

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

Some of these arrangements are called:

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

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

*For **prescription drug** services from a **network pharmacy**:*
The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third-party vendor for the **prescription drug**, and may include a rebate, an additional service or risk charge set by us.

We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the **negotiated charge** under this plan.

The following language is revised in the *Glossary* section of your booklet-certificate:

Walk-in clinic

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

- Drug store
- **Pharmacy**
- Retail store
- Supermarket

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

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

The *Wellness and other incentives* provision found in the *Discount Programs* section of your booklet-certificate is replaced by the following:

Wellness and other incentives

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 **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards, or
- Any combination of the above.

The award of a 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. And 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 is added to or replaces all provisions of the Walk-in-clinic sections of your schedule of benefits:

Alternatives to physician office visits

Walk-in clinic visits

Description	Designated network coverage	Non-designated network coverage
Non-emergency services	100% per visit, no **deductible** applies	$25 then the plan pays 100% per visit, no **deductible** applies
Preventive immunizations	100% per visit, no **deductible** applies No deductible, copayment or coinsurance applies for children through age 6	100% per visit, no **deductible** applies No deductible, copayment or coinsurance applies for children through age 6
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

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

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

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

The following is added to or replaces the cognitive therapy benefit in the *Outpatient office visit to a physician or behavioral health provider benefit in the Mental health treatment and Substance related disorders treatment sections* of your schedule of benefits:

Outpatient mental health **telemedicine** or **telehealth** cognitive therapy consultations by a **physician** or **behavioral health provider** Coverage is provided under the same terms, conditions as any other illness.	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

The Transplant services facility and non-facility provision in the *Eligible health services-Specific conditions Transplant services* section of your schedule of benefits is replaced with the following:

Eligible health services	**IOE facility**	**Non-IOE facility**
Transplant services facility and non-facility		
Transplant services and supplies	Covered according to the type of benefit and the place where the service is received	Not Covered

All references to the brand name **Texas Health + Aetna Health** in your booklet-certificate and schedule of benefits are replaced with the brand name **Texas Health Aetna**.

This amendment makes no other changes to the booklet and schedule of benefits.

Jeff Cook
Chief Executive Officer

Texas Health + Aetna Health Insurance Company
(A Stock Company)

Additional Information Provided by

Texas Operators Association

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Texas Health + Aetna Health is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Texas Operators Association

Employer Identification Number:
85-1623063

Plan Number:
501

Type of Plan:
Welfare

Type of Administration:
Group Insurance Policy with:

Texas Health + Aetna Health
612 East Lamar Boulevard, Suite 100
Arlington, TX 76011

Plan Administrator:
Texas Operators Association
8955 Katy Freeway, Suite 130
Houston, TX 77024
Telephone Number: (214) 273-3130

Agent For Service of Legal Process:
Texas Operators Association
8955 Katy Freeway, Suite 130
Houston, TX 77024

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31

Source of Contributions:
Employer and Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Senior Vice President.

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

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

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

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

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

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

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

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Confidentiality Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Open Access Network Only Plus Medical Plan

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	Texas Operators Association
Group policy number:	GP-170207-A
	Schedule of Benefits 2A
	Open Access Network Only Plus $500 Plan
Group policy effective date:	January 1, 2021
Plan effective date:	January 1, 2021
Plan issue date:	December 18, 2020

Underwritten by Texas Health + Aetna Health Insurance Company in the state of Texas.

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from any **network provider**.
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance**. The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

Important note:

Instead of a specific **copayment** or **coinsurance** percentage, you will sometimes see language that reads:

"Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*."

This means that your **copayment** or **coinsurance** 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** or **coinsurance** 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** or **coinsurance** 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** or **coinsurance**.

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Plan Benefits secure member website at www.texashealthaetna.com or at the toll-free number on your ID card.

The coverage described in this schedule of benefits will be provided under **Texas Health + Aetna Health Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

*See *How to read your schedule of benefit* at the beginning of this schedule of benefits

Plan features	Deductible/Maximums
	In-network coverage*
Deductible	
You have to meet your Calendar Year **deductible** before this plan pays for benefits.	
Individual	$500 per Calendar Year
Family	$1,000 per Calendar Year
Deductible waiver	
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives	
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$2,500 per Calendar Year
Family	$5,000 per Calendar Year

* See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies
Routine physical exams for adults age 18 or more Maximum age and visit limits per 12 months	
Screening for abdominal aortic aneurysm	1 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 age 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 45-79 years of age For women age 55-79 years of age
Additional maximum age and visit limits per 12 months	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 Plan Benefits secure member website at www.texashealthaetna.com or calling the number on your ID card.
Routine physical exams for children from birth to age 18: Maximum age and visits per 12 months	
Autism screening	At intervals of 18 and 24 months
Developmental screening	Under age 3 and surveillance throughout childhood
Blood pressure screenings at certain intervals	0-11 months 1-4 years 5-10 years 11-14 years 15-17 years

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Additional maximum age and visit limits per 12 months	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 Plan Benefits secure member website at www.texashealthaetna.com or calling the number on your ID card.
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies No **deductible** or **coinsurance** applies for children through age 6
Limited to:	
Routine physical exams for adults age 18 or more	As shown in the booklet-certificate
Routine physical exams for children from birth to age 18	As shown in the booklet-certificate
Additional maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Plan Benefits secure member website at www.texashealthaetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Pap smear or screening using liquid based cytology methods	1 pap smear every 12 months for women age 18 and older
Gynecological exam that includes a rectovaginal pelvic exam	1 exam every 12 months for women over age 25 who are at risk for ovarian cancer
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	1 exam 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 3 years for women with normal cytology results who are 30 or older
Additional maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Additional maximum visits per Calendar Year	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:	
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Misuse of alcohol and/or drugs maximums:	
Maximum visits per 12 months	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Use of tobacco products maximums:	
Maximum visits per 12 months	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Sexually transmitted infection counseling maximums:	
Maximum visits per 12 months	2 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
Mammogram maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, subject to any age, family history and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration
Prostate specific antigen (PSA) tests maximums	1 PSA test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor
Fecal occult blood tests maximums	1 occult test every 12 months for covered persons age 50 or older
Sigmoidoscopies maximums	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older
Colonoscopies maximums	1 colonoscopy every 10 years for covered persons age 50 or older
Lung cancer screening maximums	1 screening every 12 months*
Additional maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Plan Benefits secure member website at www.texashealthaetna.com or calling the number on your ID card.
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	
Breast feeding durable medical equipment	
Breast pump supplies and accessories	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.	
Family planning services – female contraceptives	
Counseling services	
Female contraceptive counseling services office visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies
Eligible health services	**In-network coverage***
Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Telemedicine or **telehealth** consultation by a **physician, PCP**	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Maximum visits per day	1
Telemedicine or **telehealth** consultation by a **specialist**	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Maximum visits per day	1

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Allergy injections	
Performed at a **physician's**, **PCP** or **specialist** office when you do not see the **physician**	90% (of the **negotiated charge**) per visit
Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*. No **deductible** or **coinsurance** applies for children through age 6
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Physician surgical services	
Physician and **specialist** office visits	
Performed at a **physician's**, **PCP** office	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed at a **specialist's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies No **deductible** or **coinsurance** applies on immunizations for children through age 6
Immunizations and routine physical exams limited to:	
For immunizations for adults age 18 or more	See the *Preventive care and wellness* section
For immunizations for children from birth to age 18	See the *Preventive care and wellness* section
Additional immunizations, maximum age and visit limits per 12 months	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Plan Benefits Navigator secure member website at www.texashealthaetna.com or calling the number on your ID card.
For routine physical exams	See the *Preventive care and wellness* section

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	**In-network coverage***
Hospital and other facility care	
Hospital care	
Inpatient **hospital**	90% (of the **negotiated charge**) per admission
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	90% (of the **negotiated charge**) per visit
Dental care services and anesthesia	
Hospital or **surgery center**	Covered according to the type of benefit and the place where the service is received
Home health care	
Outpatient	90% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	120
Hospice care	
Inpatient facility	90% (of the **negotiated charge**) per admission
Maximum days per Calendar Year	Unlimited
Hospice care	
Outpatient	90% (of the **negotiated charge**) per visit
Skilled nursing facility	
Inpatient facility	90% (of the **negotiated charge**) per admission
Maximum days per Calendar Year	100

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Emergency services and urgent care		
Emergency services		
Hospital emergency room	90% (of the **negotiated charge**) per visit No **deductible** applies	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	$250 then the plan pays 90% (of the **negotiated charge**) per visit after the **deductible**	Not Covered

Important Note:

- As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment,** and **coinsurance**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill.
- A separate hospital emergency room **copayment/coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospita**l as an inpatient right after a visit to an emergency room, your emergency room **copayment/coinsurance** will be waived and your inpatient **copayment/coinsurance** will apply.

Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	90% (of the **negotiated charge**) per visit	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder treatment	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Autism spectrum disorder diagnosis and testing	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Applied behavior analysis	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Outpatient physical, occupational and speech therapy services described under the *Habilitation therapy services* section and that are provided for the treatment of autism spectrum disorder are subject to the *Habilitation therapy services* maximums.	
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan.	
Birthing center	
Inpatient	90% (of the **negotiated charge**) per admission
Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Family planning services - other	
Voluntary sterilization for males	
Outpatient	90% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Jaw joint disorder treatment	
Jaw joint disorder treatment	90% (of the **negotiated charge**) per visit
Maternity and related newborn care	
Inpatient	90% (of the **negotiated charge**) per admission
Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	90% (of the **negotiated charge**) per visit
Other prenatal care services	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Pregnancy complications	
Inpatient	90% (of the **negotiated charge**) per admission
Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per admission
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** and **telehealth** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** and **telehealth** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** **Intensive outpatient program** Coverage is provided under the same terms, conditions as any other **illness**. The cost share doesn't apply to in-network peer counseling support services.	90% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	90% (of the **negotiated charge**) per admission
Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** or **telehealth** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** or **telehealth** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

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Other outpatient **substance use disorders** **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services	90% (of the **negotiated charge**) per visit

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	90% (of the **negotiated charge**) per visit

Reconstructive breast surgery	
Reconstructive breast **surgery**	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility)**
Transplant services facility and non-facility		
Inpatient **hospital** transplant services	90% (of the **negotiated charge**) per transplant	Not covered
Physician services including office visits	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.	Not covered

Eligible health services	**In-network coverage***
Treatment of infertility	
Basic infertility	
Basic **infertility**	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

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Eligible health services	In-network coverage*
Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
	90% (of the **negotiated charge**) per visit
Diagnostic lab work	
	90% (of the **negotiated charge**) per visit
Diagnostic radiological services	
	90% of the **negotiated charge** per visit.
Diagnostic follow-up care related to newborn hearing screening	
Diagnostic follow-up care related to newborn hearing screening	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Cardiovascular disease testing	
Cardiovascular disease testing	90% (of the **negotiated charge**) 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
Chemotherapy	
Chemotherapy	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Oral anti-cancer prescription drugs	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

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Outpatient infusion therapy	
Performed in a **physician's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies.
Performed in a person's home	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Performed in the outpatient department of a **hospital**	90% (of the **negotiated charge**) per visit.
Performed at an outpatient facility other than the outpatient department of a **hospital**	90% (of the **negotiated charge**) per visit.
Outpatient radiation therapy	
	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Pulmonary rehabilitation	
Pulmonary rehabilitation	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Short-term rehabilitation services	
Outpatient Physical, Occupational and Speech Therapies	
	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Outpatient Physical, Occupational and Speech Therapy Maximum	
Maximum visits per Calendar Year	60 visits

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Spinal manipulation	
Spinal manipulation	$25 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies
Maximum visits per Calendar Year	20

Habilitation therapy services	
	90% (of the **negotiated charge**) per visit

Inpatient and outpatient treatment for acquired brain injury	
Acquired brain injury	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.

Eligible health services	In-network coverage*
Other services	

Acupuncture	
Acupuncture	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits.*

Alzheimer's disease	
Alzheimer's disease	Covered according to the type of benefit and the place where the service is received
Ambulance service	
Ground, air or water **ambulance**	90% (of the **negotiated charge**) per visit

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits.*
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits.*

Durable medical equipment (DME)	
DME	90% (of the **negotiated charge**) per item

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Hearing aid exams	
Hearing aid exams	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits*.
Hearing aids and cochlear implants and related services	
Hearing aids and cochlear implants and related services	90% (of the **negotiated charge**) per visit thereafter
Hearing aids	One per ear every three years
Replacement of cochlear implant external speech processor and controller components	Once every three years

Non-routine/non-preventive hearing exams	
For adults and children	100% (of the **negotiated charge**) per visit No **deductible** applies
Maximum	One exam in any 24 consecutive month period
Nutritional supplements	
Nutritional supplements	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits.*
Orthotic devices	
Orthotic devices	90% (of the **negotiated charge**) per item

Osteoporosis	
Physician's office visit	Depending upon where the **eligible health service** is provided, benefits will be the same as those stated under each **eligible health service** category in this *Schedule of benefits.*
Prosthetic devices	
Prosthetic devices	90% (of the **negotiated charge**) per item

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Vision care	
Routine vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	100% per visit No **deductible** applies

Maximum visits per 24 consecutive month period	1 visit

Eligible health services	In-network coverage*
Outpatient prescription drugs	
Plan features	**Deductible/Copayment/Coinsurance/Maximums**
Deductible waiver	
The Calendar Year **deductible** is waived for all **prescription drugs**.	
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs	
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.	
Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs	
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%.	
Deductible and copayment/coinsurance waiver for contraceptives	
The Calendar Year **deductible** and the per **prescription copayment/coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. The Calendar Year **deductible** and the per **prescription copayment/coinsurance** continue to apply to **prescription drugs** that have a generic equivalent or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.	

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Preferred generic prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$25 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$25 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
Non-preferred generic prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$175 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$175 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies

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Preferred brand-name prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$40 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$100 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$100 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
Non-preferred brand-name prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$175 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$175 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies

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Other services	
Preventive contraceptives	
Per prescription copayment/coinsurance	
For each fill up to a 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
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
Nutritional supplements	
Per prescription copayment/coinsurance	
For each fill up to a 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
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
Off-label use	
Per prescription copayment/coinsurance	
For each fill up to a 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
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

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Orally administered anti-cancer prescription drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **retail pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$0 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
Preferred specialty drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$70 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies
Non-preferred specialty drugs	
Per prescription copayment/coinsurance	
For each fill up to a 30 day supply filled at a **retail pharmacy**	$90 **copayment** per supply **Coinsurance** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies

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Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.texashealthaetna.com or calling the number on of your ID card.
Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your secure member website at www.texashealthaetna.com or calling the number on your ID card.
Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy**	$0 per **prescription** or refill No **deductible** applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your secure member website at www.texashealthaetna.com or calling the number on your ID card.
If a **prescriber** prescribes a covered **brand-name prescription drug** where **a generic prescription drug** equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If a **prescriber** does not specify DAW and you request a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between **the brand-name prescription drug** and the **generic prescription drug**, plus the cost sharing that applies to the **brand-name prescription drug**.	

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Important note: 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 you bought it without using your plan or any other **prescription drug** benefits or discounts.

You may later have to pay additional cost sharing for these **prescription drugs**. For example, if you have not met your **prescription drug deductible** (if applicable), you may owe additional cost sharing.

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General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**

that are listed in the first part of this schedule of benefits.

Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the **deductible** does not apply.

Individual
This is the amount you owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family
This is the amount you and your covered dependents owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments

Copayment
As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Coinsurance

The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/**coinsurance and **deductibles** for **eligible health services** during the Calendar Year. This plan has 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.

Individual

Once the amount of the **copayments/**coinsurance and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar 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 **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/coinsurance** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services

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Calculations; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of 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 Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the certificate.

Outpatient prescription drug maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **eligible health services** provided under the medical plan and the outpatient **prescription drug** plan.