INTRODUCTION TO YOUR INDIVIDUAL ADVANTAGE CONTRACT

Welcome and thank you for choosing **Aetna** for your health benefits. We are pleased to provide you with this **Contract**. This **Contract** and other plan documents describe what is covered and how your plan works. All the conditions and provisions of the **Contract** apply to you and your eligible dependents covered under this plan.

What is Included

The **Contract** describes how to use your plan, what services are covered, the portion of the health care cost we pay, and the portion of the health care costs you will be required to pay.

This **Contract** takes the place of all policies **Aetna** may have provided to you earlier that describe this kind of insurance.

How to Use This Document

You should read this **Contract** carefully. You are responsible for understanding the terms and conditions in this **Contract**. This **Contract** also includes the *Schedule of Benefits,* amendments, and riders.

This **Contract** contains exclusions and limitations. Please be sure to read the *Medical* and *Prescription Benefit Exclusions* sections carefully.

Common Terms

The Definition section at the back of this document defines many terms used in this **Contract**. Defined terms appear in bolded print. Knowing these terms will

- Help you know how your plan works
- Give you useful information about your plan.

How to Contact Us

We are available to answer questions you may have related to your coverage or benefits. Please see the *Contact Us* section of the **Contract** for a listing of Our website, mailing address and telephone number.

THE NEVADA DIVISION OF INSURANCE PROVIDES A TOLL FREE TELEPHONE NUMBER WHICH NEVADA CONSUMERS MAY USE FOR INQUIRIES AND COMPLAINTS REGARDING HEALTH PLANS. ---1-888-872-3234 --- HOURS OF OPERATION ---8 AM TO 5 PM WEEKDAYS---

NOTICE TO SUBSCRIBER

For a period of ten days from the date this Individual Advantage Contract is delivered to you, this Individual Advantage Contract may be returned to the agent through whom you applied for coverage or surrendered to Aetna together with written request for cancellation of the Contract. Aetna will refund any Premium paid including any contract fees or other charges, if any, less the cost of any services paid on behalf of the Subscriber or any Covered Dependent. The Contract will be deemed void from the beginning.

IMPORTANT NOTICE
Please read the copy of the application attached to this contract. If any information on it is not correct and complete, please write to **Aetna** at the address above within 10 days.

Your application has now become part of the contract, which has been issued exclusively relying on the information given in your answers to all questions shown in the application for coverage under this contract. Any misrepresentation or fraudulent inducement in the information and/or answers submitted as part of the application process may, at Aetna's discretion, result in the rescission of this contract and in federal and state prosecution in accordance with federal and state laws. Before any coverage is rescinded, you will be given an opportunity to appeal this decision. Please see the Complaint and Appeals section of the contract.

Your review of this application now will help prevent cases of misstatements or misunderstandings.

AETNA HEALTH INC.
(NEVADA)
4040 S. Eastern Ave., Suite 240
Las Vegas, NV 89119

INDIVIDUAL ADVANTAGE CONTRACT

This is an Individual Advantage **Contract** (hereinafter referred to as "**Contract"** between Aetna Health Inc., hereinafter referred to as **Aetna,** and the **Contract Holder**. Th**is Contract** determines the terms and conditions of coverage. The **Contract** describes covered health care benefits. Provisions of this **Contract** include the Enrollment Form, *Schedule of Benefits*, and any amendments, endorsements, inserts, or attachments. Amendments, endorsements, inserts, or attachments may be delivered with the **Contract** or added thereafter.

If any provision of this **Contract** is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this **Contract** shall continue in full force and effect. In consideration of the **Premium** payments made by or on behalf of the **Contract Holder**, **Aetna** shall provide coverage for those services described in this **Contract** subject to the terms and conditions set forth in this **Contract**.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation section of this **Contract**.

Certain words have specific meanings when used in this **Contract**. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this **Contract**.

This Contract is not in lieu of insurance for Workers' Compensation. This Contract is governed by applicable federal law and the laws of Nevada.

READ THIS ENTIRE CONTRACT CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND AETNA. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CONTRACT.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRECERTIFICATION BY AETNA.

NO SERVICES ARE COVERED UNDER THIS CONTRACT IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE CONTRACT.

THIS CONTRACT APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS CONTRACT.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF AETNA.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Contract. Benefits may be modified during the term of this plan as specifically provided under the terms of the Contract or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Contract.

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AETNA PROCEDURE

Selecting a Participating Primary Care Physician

At the time of enrollment, each **Member** is required to select a **Participating Primary Care Physician** (**PCP)** from **Aetna's** Directory of Participating Providers to access **Covered Benefits** as described in this **Contract**. The choice of a **PCP** is made solely by the **Member**. If the **Member** is a minor or otherwise incapable of selecting a **PCP**, the **Subscriber** should select a **PCP** on the **Member's** behalf. If the **Member** does not select a **PCP** within a reasonable time after being eligible for **Covered Benefits**, the **HMO** will designate a **PCP** for the **Member** and notify the **Member** of such selection. The **Member** can change the selection of **PCP** thereafter. The **PCP** is not an agent or employee of the **HMO** and the selection of a **PCP** by **HMO** is merely a convenience for **Members** to provide access to **Covered Benefits**

The Primary Care Physician

The **PCP** coordinates a **Member's** medical care, as appropriate, either by providing treatment or by issuing **Referrals** to direct the **Member** to another **Participating Provider**. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

Except in a **Medical Emergency** or for certain direct access **Specialist** benefits as described in this **Contract**, only those services which are provided by or referred by a **Member's PCP** will be covered. **Covered Benefits** are described in the Covered Benefits section of this **Contract**. It is a **Member's** responsibility to consult with the **PCP** in all matters regarding the **Member's** medical care.

Certain **PCP** offices are affiliated with integrated delivery systems or other provider groups (i.e., Independent Practice Associations and Physician-Hospital Organizations), and **Members** who select these **PCPs** will generally be referred to **Specialists** and **Hospitals** within that system or group. However, if the group does not include a **Provider** qualified to meet the **Member's** medical needs, the **Member** may request to have services provided by nonaffiliated **Providers**.

In certain situations where a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. Please refer to the Covered Benefits section of this **Contract** for details.

If the **Member's PCP** performs, suggests, or recommends a **Member** for a course of treatment that includes services that are not **Covered Benefits**, the entire cost of any such non-covered services will be the **Member's** responsibility.

Covered Benefits also include **Telemedicine through TelaDoc.** Registration with an internet service vendor may be required**.** Information about **TelaDoc** who conduct **Telemedicine** consultations may be found in the provider Directory, online in DocFind on www.Aetna.com or by calling the number on your **Member** identification card.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **Provider** or Participating Medical Group in the Aetna Value Network. Either **Aetna** or any **Participating Provider**

may terminate the **Provider** contract or limit the number of **Members** that will be accepted as patients. If the **PCP** initially selected cannot accept additional patients, the **Member** will be notified and given an opportunity to make another **PCP** selection from the Participating Medical Group in the Aetna Value Network. The **Member** must then cooperate with **Aetna** to select another **PCP**. If the **Member** does not select a **PCP** within a reasonable time after being eligible for **Covered Benefits**, the **HMO** will designate a **PCP** for the **Member** and notify the **Member** of such selection. The **Member** can change the selection of **PCP** thereafter. The **PCP** is not an agent or employee of the **HMO** and the selection of a **PCP** by **HMO** is merely a convenience for **Members** to provide access to **Covered Benefits.**

Changing a PCP

You may change your **PCP** at any time by calling the Member Services toll-free telephone number listed on the **Member's** identification card or by written or electronic submission of the **Aetna's** change form. A **Member** may contact **Aetna** to request a change form or for assistance in completing that form. The change will become effective upon **Aetna**'s receipt and approval of the request.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by **Health Professionals** to determine whether such services and supplies are **Covered Benefits** under this **Contract**. If **Aetna** determines that the recommended services and supplies are not **Covered Benefits**, the **Member** will be notified. If a **Member** wishes to appeal such determination, the **Member** may then contact **Aetna** to seek a review of the determination. Please refer to the **Claim Procedures/Complaints and Appeals** section of this **Contract**.

The Referral Process
Except for **PCP**, direct access and emergency or **Urgent Care** services, you must have a prior written or electronic **Referral** from your **PCP** to receive the plan's network level of coverage for all services and any necessary follow-up treatment.

How Referrals Work

Here are some important points to remember:

- When your **PCP** determines that your treatment should be provided by a **Specialist** or **Hospital** or other health care professional, you will receive a written or electronic **Referral**. The **Referral** will be good for 60 days, as long as you remain covered under the plan.

- Go over the **Referral** with your **PCP**. Make sure you understand what types of services have been recommended and why.

- When you visit the provider or facility, bring the **Referral** (or check in advance to verify that they have received the electronic **Referral**). Without it, you will receive out-of-network coverage even if you receive your treatment from a **Participating Provider**.
- Certain services such as inpatient stays, outpatient surgery and certain other medical procedures and tests require both a **PCP referral** and **Precertification**. **Precertification** verifies

that the recommended treatment is a **Covered Benefit** as described in the ***Covered Benefit*** section. This is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that you were not eligible for benefits at that time. Your **PCP** or other **Participating Providers** are responsible for obtaining **Precertification** for you.

- You cannot request a **Referral** from your **PCP *after*** you have received services or supplies from a **Specialist** or **Hospital**.

- If a service or supply that you need is not available from a **Participating Provider**, your **PCP** may **refer** you to an **Non-Participating Provider**. Your **PCP** or other network **Physician** must get pre-approval from **Aetna** for services from **Non-Participating Providers** so that **Covered Benefits** can be covered at the network level of benefits as shown in your *Schedule of Benefits*.

Ongoing Specialist Care

If you have a condition which requires ongoing care from a **Specialist**, you or your **Physician** may request a standing **Referral** to such **Specialist**. Circumstances which may warrant this type of **Referral** include, but are not limited to, a high risk pregnancy or dialysis treatment. You should initially make this **Request** through your **PCP**. If **Aetna,** the **PCP** and/or **Specialist,** in consultation with a medical director, determine that such a standing **Referral** is appropriate, **Aetna** will authorize such a **Referral** to **Specialist** who is a **Participating Provider**. **Aetna** is not required to permit you to elect a **Specialist** who is an **Non-Participating Provider**, unless such a **Specialist** is not available within the network. Any authorized **Referral** shall be made pursuant to a treatment plan approved by **Aetna** in consultation with the **PCP**, the **Specialist** and you, or your designee.

The treatment plan may limit the number of visits or the period during which the visits are authorized and may require the **Specialist** to provide the **PCP** with regular updates on the specialty care provided, as well as all necessary medical information.

When You Don't Need a PCP Referral

You don't need a **PCP referral** for:

- **Emergency care** – See *Coverage for Emergency Medical Conditions*.
- **Urgent care** – See *Coverage for Urgent Conditions*.
- **Direct access services** – Services from **Participating Providers** for which the **Referra**l is not required. Certain routine and preventive services do not require a **Referral** under the plan when accessed in accordance with the age and frequency limitations outlined in the ***Covered Benefits*** section and *the Schedule of Benefits*. Refer to the ***Covered Benefits*** section for information on when these benefits are covered. You can directly access these **Participating Specialists** for:

  - Routine gynecological and Pap smear visits
  - Obstetrical services
  - Annual screening mammogram for age-eligible women
  - Routine prenatal care
  - Routine eye exams, including refraction
  - Preventive Dental Care for your dependents under the age of 19

Precertification

Certain services and supplies under this **Contract** may require precertification by **Aetna** to determine if they are **Covered Benefits** under this **Contract.**

Continuity of Care

Existing Enrollees

The following applies when your **Hospital** or **Physician**:

- Stops participation with **Aetna** as a **Participating Provider** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the heath professional's ability to practice;

Aetna will continue coverage for an ongoing course of treatment with your current **Hospital** or **Physician** during a transitional period. Coverage shall continue for up to 120 days from the date of notice to you from **Aetna** that the provider terminated participation with **Aetna** as a **Participating Provider if:**

- The **Member** is actively undergoing a **Medically Necessary** course of treatment
- The health care **Provider** and the **Member** agree that the continuity of care is desirable

If the medical condition is pregnancy, the transitional period will extend to the 45th day:

- After the date of delivery
- If the pregnancy does not end in a delivery, the date the pregnancy ended

The coverage will be authorized by **Aetna** for the transitional period only if the **Hospital** or **Physician** agrees:

- To accept reimbursement at the **Negotiated Charge** and cost sharing applicable prior to the start of the transitional period as payment in full;
- To adhere to quality standards and to provide medical information related to such care; and
- To adhere to **Aetna's Contract** and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this **Contract**.

With regards to the continuity of coverage provisions described above, the notice of the event provided to you by **Aetna** will include specific instructions on how to request continuity of coverage during the transitional period.

New Enrollees

If your current **Hospital** or **Physician** does *not* have a contract with **Aetna**, new enrollees may continue an ongoing course of treatment with their current **Hospital** or **Physician** for a transitional period of up to 90 days from the effective date of enrollment.

If the medical condition is pregnancy, the transitional period will extend to the 45th day:

- After the date of delivery
- If the pregnancy does not end in a delivery, the date the pregnancy ended

You need to complete a *Transition of Coverage Request* form and send it to **Aetna**. Contact Member Services at the number on the back of your ID card for a copy of this form. If authorized by **Aetna**, coverage will be provided for the transitional period but only if the **Hospital** or **Physician** agrees to:

- Accept reimbursement at the **Negotiated Charge** and cost-sharing established by **Aetna** prior to the start of the transitional period as payment in full;
- Adhere to quality standards and to provide medical information related to such care; and
- Adhere to **Aetna's Contract** and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this **Contract**.

ELIGIBILITY AND ENROLLMENT

Who is Eligible to be Covered

Throughout this section there is information on who can be covered under this Contract, and what to do when there is a change in the Member's life that affects coverage.

The **Contract Holder** is:

- A legal resident of the State of Nevada;
- Not eligible for or enrolled in Medicare at the time of application;
- Listed as the applicant on the application;
- Approved by **HMO;**
- Not covered by any other group or individual health plan.

Covered dependents are the following members of the **Contract Holder's** family who are eligible, are residents of the state in which the Contract was issued and have been approved by **HMO**:

- Your spouse.
- Your domestic partner. A domestic partner under this Policy is a person of the same or opposite sex as the Policyholder, who has been issued a Certificate of Registered Domestic Partnership with the Policyholder by the State of Nevada, Office of the Secretary of State.
- Your or your covered spouse's, or your covered domestic partner's children who are under 26 years of age.

Eligible dependent children include:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Any children for whom you are responsible under court order.

Special Circumstances:

- Newborns of the **Contract Holder**, covered spouse or covered domestic partner are automatically covered for the first 60 days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING **HMO** IN WRITING WITHIN 60 DAYS OF BIRTH. THE **CONTRACT HOLDER** WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.
- A child being adopted by the **Contract Holder** or covered domestic partner will have coverage for the first 60days from the date of the adoption if the child was not placed in the home of the **Contract Holder** before adoption. A child placed with the **Contract Holder** for the purpose of adoption will have coverage up to sixty (60) days from the moment of placement as certified by the public or private agency making the placement. The coverage of a child placed with the **Contract Holder** for the purpose of adoption ceases if the adoption proceedings are terminated as certified by the public or private agency making the

placement. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A FAMILY MEMBER BY NOTIFYING US IN WRITING WITHIN 60 DAYS OF THE DATE THE **CONTRACT HOLDER'S** OR COVERED DOMESTIC PARTNER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. THE **CONTRACT HOLDER** WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF ADOPTION OR MOMENT OF PLACEMENT.

- Newborns who are the children of a **Contract Holde**r's covered dependent under this contract are automatically covered for the first 60 days under this Contract. TO CONTINUE COVERAGE, THE GRANDCHILD MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING **HMO** IN WRITING WITHIN 60 DAYS OF BIRTH. THE **CONTRACT HOLDER** WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUM CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH. Coverage for handicapped dependent children may continue after your dependent child reaches the limiting age. See the *Continuation* section for more information.

Effective Date of Coverage for Dependents
Coverage for your dependents will take effect on the first or the 15th of the month after approved by **HMO** and consistent with your Premium Due Date (as shown on your *Insert A*).

Notice of Change in Eligibility
You must notify **HMO** of all changes affecting your or any covered dependent's eligibility under this Contract within 31 days of the change.

Failure to notify **HMO** of the change within the designated 31 day timeframe may result in **HMO**'s denying the request for a retroactive eligibility date.

How And When To Enroll

Initial Enrollment In The Plan

You will be provided with plan benefit and enrollment information when you first decide to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions.

Special Enrollment Periods

HMO may offer general enrollment periods in your state. If so, and you do not enroll during this time period, you may enter the plan if you qualify:

- under a federal *Special Enrollment Period; or*
- after you complete a 90 day waiting period that starts after the date on which the application for coverage was received.

Your coverage will be effective on the first day of the month immediately succeeding the month in which the waiting period expires; and is not retroactive to the date on which the application for coverage was received.

Loss of Other Health Care Coverage

These are some of the reasons that you or your dependents may qualify for a *Special Enrollment Period*:

- You did not enroll yourself or your dependent during a general enrollment period because, at that time:
  - You or your dependents were covered under other another plan; and
- You or your dependents are no longer eligible for the other plan because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - Employer contributions toward that coverage have ended;
  - The employer's decision to stop offering a group health plan to the eligible class to which you belong;
  - The ending of the other plan's coverage;
  - COBRA coverage ends;
  - Death;
  - Divorce or legal separation;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another plan for all benefits under that plan.

Please contact **HMO** at www.**aetna.com** for detailed information regarding Special Enrollment Periods.

Enrollment of Newly Eligible Dependents.

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and, within the limits of this **Contract,** necessary transportation costs from place of birth to the nearest specialized **Participating** treatment center.

For Adopted Children:

The initial coverage will not be affected by any provision in this **Contract** which delays coverage due to a confinement.

COVERED BENEFITS

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **Contract**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **Aetna** may determine whether any benefit provided under the **Contract** is **Medically Necessary**, and **Aetna** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

Important Note:
You should review your *Schedule of Benefits* for the cost sharing that applies to the **Covered Benefits** in this section. This will help you become familiar with your payment responsibilities.

Some **Covered Benefits** may have visit limits and maximums that apply to the service or supply. You should always review your **Contract** and *Schedule of Benefits* together.

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THIS CONTRACT.

To be **Medically Necessary**, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- Be care or services related to diagnosis or treatment of an existing illness or injury, except for Preventive Care Benefits, as determined by **Aetna**;

- Be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce

a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member's** overall health condition;

- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician's** office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **Aetna's** Patient Management Medical Director or its **Physician** designee will consider:

- Information provided on the **Member's** health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of **Health Professionals** in the generally recognized health specialty involved;
- The opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- Any other relevant information brought to **Aetna**'s attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **Aetna**.

If a **Member** has questions regarding coverage under this **Contract**, the **Member** may call the Member Services toll-free telephone number listed on the **Member's** identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS AND DEDUCTIBLES LISTED ON THE *SCHEDULE OF BENEFITS*.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS CONTRACT, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP'S OFFICE THAT IS SHOWN ON THE MEMBER'S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER'S PCP.

1. Preventive Care and Wellness Benefits

Preventive Care

1. The recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- United States Preventive Services Task Force;

- Health Resources and Services Administration; and
- American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents

as referenced throughout this Preventive Care Benefit may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

2. If any *diagnostic* x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care services described below, those diagnostic x-rays, lab or other tests or procedures will not be covered as Preventive Care Benefits. Those that are **Covered Benefits** will be subject to the cost-sharing that applies to those specific services under this Plan.

3. Gender- Specific *Preventive Care Benefits* -- **covered expenses** include any recommended *Preventive Care Benefits* described below that are determined by your provider to be **medically necessary,** 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 the Aetna Navigator® secure member website at www.aetna.com or calling the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine Physical Exam Benefit

Covered Benefits include office visits to a **Member's Primary Care Physician (PCP)** for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a **PCP** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

    - Screening and counseling services, such as those on:
        - Interpersonal and domestic violence;
        - Sexually transmitted diseases; and
        - Human Immune Deficiency Virus (HIV) infections.
    - Screening for gestational diabetes for women.
    - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **Hospital** check up.

Benefits for the routine physical exam services above may be subject to visit maximums as shown in the *Schedule of Benefits.*

For details on the frequency and age limits that apply to Routine Physical Exam Benefit, **Members** may contact their **Physician** or **Member Services** by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a H**ospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations Benefit

Covered Benefits include:

- Immunizations for infectious diseases;
- The HPV vaccination for ages 9 and over; and
- The materials for administration of immunizations;

provided by a **Member's PCP** or a facility. The immunizations must be recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Benefit Limitations:
Not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan; and
- Immunizations that are not considered preventive care such as those required due to a **Member's** employment or travel.

Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy;** and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- *Aspirin:* Benefits are available to adults.
- *Oral Fluoride Supplements:* Benefits are available to children whose primary water source is deficient in fluoride.
- *Folic Acid Supplements:* Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- *Iron Supplements:* Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.

- *Vitamin D Supplements:* Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk Reducing Breast Cancer Prescription Drugs: **covered expenses** include charges incurred for preferred, generic, brand-name, biosimilar **prescription drugs** prescribed by a **prescriber** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage of preventive care drugs and supplements 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.

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging on to your Aetna Navigator® secure member website at www. Aetna.com or at the toll-free number on your ID card.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

Reimbursement of Preventive Care Drugs and Supplements at a Pharmacy

You will be reimbursed by **Aetna** for the cost of the preventive care drugs and supplements when you submit proof of loss to **Aetna** that you purchased a preventive care drug or supplement at **a pharmacy**. "Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (it is attached to the bag that contains the preventive care OTC drug or supplement).

Refer to the provisions *Proof of Loss and Claims Payment* later in this contract for information. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Well Woman Preventive Visits Benefit

Covered Benefits include a routine well woman preventive exam office visit, including pap smears, cytologic screenings, and rectovaginal pelvic exams for women age 25 and over who are at risk of ovarian cancer provided by a **Member's PCP, Physician,** obstetrician, or gynecologist for:

- A routine well woman preventive 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; and
- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered Benefits** include charges made by a **Physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given while the **Member** is confined in a H**ospital** or other facility for medical care;
- Services not given by a **Physician** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services Benefit

Covered Benefits include the following services provided by a **Member's PCP** or **Physician,** as applicable**,** in an individual or group setting:

Obesity and/or Healthy Diet Benefit

Covered Benefits include screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- 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 Benefit

Covered Benefits include screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Use of Tobacco Products Benefit

Covered Benefits include screening and counseling services to aid in the cessation of the use of tobacco products.

Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid in the cessation of the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:

- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;

- Smokeless tobacco; and
- Candy-like products that contain tobacco.

Sexually Transmitted Infection Counseling
Covered Benefits include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risk Counseling for Breast and Ovarian Cancer
Covered Benefits include the counseling and evaluation services to help you assess whether or not you are at risk of breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above are subject to any visit maximums as shown in the *Schedule of Benefits***.**

Benefit Limitations:
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this **Contract**.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Covered Benefits include all 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.

Routine Cancer Screenings Benefit

Covered Benefits include, but are not limited to, the following routine cancer screenings:
- One baseline mammogram for covered females age 35 to 40
- An annual mammogram for covered females age 40 and over;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enema (DCBE); and
- Colonoscopies; (including the removal of polyps performed during a screening procedure); and
- Lung cancer screenings.

Prostate and colorectal cancer screenings and laboratory services in accordance with:
- The guidelines concerning these cancer screenings which are published by the American Cancer Society; or
- Other guidelines or reports concerning these cancer screenings which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

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; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

For details on the frequency and age limits that apply to Routine Cancer Screenings Benefit, **Members** may contact their **Physician** or **Member Services** by logging onto the Aetna Navigator website www.aetna.com, or calling the toll-free number on the back of the ID card.

As to routine gynecological exams performed as part of a routine cancer screening, the **Member** may go directly to a **Participating** obstetrician (OB), gynecologist (GYN)**, o**bstetrician/gynecologist (OB/GYN) without a **Referral** from the **PCP.** See the **Direct Access Specialist Benefits** section of the **Contract**, for a description of this provision.

Benefit Limitations:
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.

Prenatal Care Benefit

Covered Benefits include prenatal care services received by a pregnant female in a **PCP, Physician's**, OB/GYN, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this *Preventive Care* benefit is limited to pregnancy-related **Physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

Benefit Limitations:
Unless specified above, not covered under this benefit are:
- Services which are covered to any extent under any other part of this Plan; and
- Services for maternity care (other than prenatal care as described above).

Important Note:
Refer to the:
- *Maternity Care and Related Newborn Care Benefits* section of the **Contract**; and
- **Prenatal Care Services, Delivery Services and Postpartum Care Services** cost-sharing in the *Schedule of Benefits***;**

for more information on coverage for services related to maternity care under this Plan.

Comprehensive Lactation Support and Counseling Services Benefit

Covered Benefits include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered Benefits** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **Covered Benefits** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown later in this amendment**.**

Breast Feeding Durable Medical Equipment

Covered Benefits includes the rental or purchase of breast feeding **Durable Medical Equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pumps

Covered Benefits include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **Hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.

- If a breast pump is purchased within the previous three year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.

Breast Pump Supplies

Coverage is 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. A **Member** is responsible for the entire cost of any additional pieces of the same or similar equipment purchased or rented for personal convenience or mobility.

Aetna reserves the right to limit **Covered Benefits** to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Benefit Limitations:
Unless specified above, not covered under this benefit are services which are covered to any extent under any other part of this Plan.

Family Planning Services - Female Contraceptives Benefit

For females with reproductive capacity, **Covered Benefits** include those services and supplies that are provided to a **Member** to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **PCP, Physician,** OB/GYN, obstetrician or gynecologist. Such counseling services are **Covered Benefits** when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum as shown later in this amendment**.**

The following contraceptive methods are **Covered Benefits** under this benefit:

Voluntary Sterilization

Covered Benefits include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Covered Benefits under this benefit would not include a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of the confinement.

Contraceptives

Covered expenses include charges made by a **physician** or **pharmacy** for:

- Services and supplies needed to administer or remove a covered contraceptive **prescription drug** or device;
- Female oral and injectable contraceptive that are **generic prescription drugs**;
- Female contraceptive devices that are generic devices and brand name devices;
- FDA-approved female:
    - generic emergency contraceptives methods approved by the FDA. To the extent one of the emergency contraceptive methods are not available as a generic, a brand name emergency contraceptive will be covered.
    - Generic over-the-counter (OTC) emergency contraceptives for which a **prescription** is not needed.
      Coverage is limited to 1 emergency contraceptive(s) per month.
- FDA-approved female generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per **prescription**.

When contraceptive methods are obtained at a **pharmacy**, **prescriptions** must be submitted to the pharmacist for processing.

Reimbursement of Over-the-Counter (OTC) Contraceptives at a Pharmacy

The FDA-approved OTC contraceptives described above are covered under this Plan when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

You will be reimbursed by **Aetna** for the cost of the OTC contraceptive when you submit proof of loss to **Aetna** that you purchased the OTC contraceptive. "Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (that is attached to the bag that contains the OTC contraceptive).

Refer to the provisions *Proof of Loss and Claims Payment* later in this contract for information on submitting claims. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact your **physician** or Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Important Notes:

1. Coverage under this *Preventive Care* benefit does not include contraceptive methods that are:
   - **Brand-name prescription drugs**;
   - Brand-name contraceptive devices;
   - **Biosimilar prescription drugs**;
   - FDA-approved female:
     - Brand-name and biosimilar emergency contraceptives methods approved by the FDA. To the extent one of the emergency contraceptive methods are not available as a generic, a brand name emergency contraceptive will be covered.
     - Brand-name over-the-counter (OTC) emergency contraceptives; and
   - FDA-approved female and male brand-name over-the-counter (OTC) contraceptives;

<u>unless</u>:

- Such contraceptive methods are not available within the same **therapeutic drug class**; or
- A generic equivalent, biosimilar or generic alternative, within the same **therapeutic drug class** is not available; and
- You are granted a medical exception.

You or your **prescriber** may seek a medical exception by submitting a request to **Aetna's** *Precertification Department*. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case **medically necessary** determination and coverage will not apply or extend to other covered persons.

1. A *generic equivalent* contains the identical amounts of the same active ingredients as the **brand name prescription drug** or device. A biosimilar is a biological drug that is therapeutically similar to a **brand name prescription drug**. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

2. Refer to the *Outpatient Prescription Drug Expenses* section of this *Contract* for more information on **prescription drug** coverage under this Plan.

Important Reminder:
Refer to the section *"Your Pharmacy Benefit"* later in this **Contract** for additional coverage of female contraceptives.

Benefit Limitations:
Unless specified above, not covered under this benefit are:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a **Physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods, sterilization procedures or devices; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Family Planning Services - *Other*

Covered Benefits include charges for the following family planning services, even though not provided to treat an illness or injury:

- Voluntary sterilization for males.

Benefit Limitations:
Not covered under this benefit are charges incurred for:
- Voluntary termination of pregnancy;
- Male contraceptive methods or devices;
- Reversal of voluntary sterilization procedures, for males and females including related follow-up care;
- Charges for services which are covered to any extent under any other part of this plan; and
- Charges incurred for family planning services while confined as an inpatient in a **Hospital** or other facility.

Important Notes:
- Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Family Planning Services - Other*.
- For more information, see the sections on *Family Planning Services - Female Contraceptives*, *Pregnancy Expenses* and *Treatment of Infertility* in this **Contract**.

2. Physician and Other Health Professional Care

Primary Care Physician Benefit

Covered Benefits include:

- Office visits during office hours.
- Home visits.
- After-hours **PCP** services. **PCPs** are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a **Member** becomes sick or is injured after the **PCP's** regular office hours, the **Member** should:

  - call the **PCP's** office;
  - identify himself or herself as a **Member**; and
  - follow the **PCP's** or covering **Physician's** instructions.

If the **Member's** injury or illness is a **Medical Emergency**, the **Member** should follow the procedures outlined under the Emergency Care/**Urgent Care** Benefits section of this **Contract**.

- **Hospital** visits.
- Immunizations for infectious disease, but not if solely for your employment or travel.
- Allergy testing and allergy injections.
- Charges made by the **Physician** for supplies, radiological services, x-rays, and tests provided by the **Physician**.

Alternatives to Physicians' Office Visits

Telemedicine Consultation by TelaDoc

Covered Benefits include charges made by your **PCP** for a routine, non-emergency, medical consultation. You must make your **Telemedicine** consultation appointment through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetna.com or by calling the number on your identification card.

Specialist Physician Benefits

Covered Benefits include outpatient and inpatient services.

If a **Member** requires ongoing care from a **Specialist**, the **Member** may receive a standing **Referral** to such **Specialist**. If **PCP** in consultation with a **Aetna** Medical Director and an appropriate **Specialist** determines that a standing **Referral** is warranted, the **PCP** shall make the **Referral** to a **Specialist**. This standing **Referral** shall be pursuant to a treatment plan approved by the **Aetna** Medical Director in consultation with the **PCP**, **Specialist** and **Member**.

Member may request a second opinion regarding a proposed surgery or course of treatment recommended by **Member's PCP** or a **Specialist**. Second opinions must be obtained by a **Participating Provider** and are subject to precertification. To request a second opinion, **Member** should contact their **PCP** for a **Referral**.

Covered Benefits also include **Telemedicine consultations.** Registration with an internet service vendor may be required**.** Information about **Participating Providers** who conduct consultations may be found in the provider Directory, online in DocFind on www.Aetna.com or by calling the number on your **Member** identification card.

Direct Access Specialist Benefits.

The following services are covered without a **Referral** when rendered by a **Participating Provider**.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.

- Direct Access to Gynecologists. Benefits are provided to female **Members** for services performed by a **Participating** gynecologist for diagnosis and treatment of gynecological problems.

Important Reminder:
For a description of the preventive care benefits covered under this **Contract**, refer to the *Preventive Care Benefits* section in this **Contract**.

3. Hospital and Other Facility Care

Hospital Benefit

Covered Benefits include inpatient **Hospital** stays. A **Member** is covered for services only at **Participating Hospitals**. All services are subject to precertification by **Aetna**. In the event that the **Member** elects to remain in the **Hospital** after the date that the **Participating Provider** and/or the **Aetna** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Hospital** Facility for such additional **Hospital, Physician** and other **Provider** services, and **Aetna** shall not be financially responsible for such additional services.

Inpatient **Hospital** cardiac and pulmonary rehabilitation services are covered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and precertification by **Aetna**.

Skilled Nursing Facility Benefit

Covered Benefits include stays in a **Skilled Nursing Facility**. A **Member** is covered for services only at **Participating Skilled Nursing Facilities**. All services are subject to precertification by **Aetna**. In the event that the **Member** elects to remain in the **Skilled Nursing Facility** after the date that the **Participating Provider** and/or the **Aetna** Medical Director has determined and advised the **Member** that the **Member** no longer meets the criteria for continued inpatient confinement, the **Member** shall be fully responsible for direct payment to the **Skilled Nursing Facility** for such additional **Skilled Nursing Facility, Physician** and other **Provider** services, and **Aetna** shall not be financially responsible for such additional services.

Outpatient Surgery Benefit

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a **Participating** outpatient surgery center. All services and supplies are subject to precertification by **Aetna**.

Home Health Benefit

Covered Benefits include the following services for a **Homebound Member** when provided by a **Participating** home health care agency. **Precertification** must be obtained from the **Aetna** by the **Member's** attending **Participating Physician**. **Aetna** shall not be required to provide home health benefits when **Aetna** determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide covered health care services. Coverage for **Home Health Services** is not determined by the availability of caregivers to perform the services; the absence of a person to perform a non-skilled or **Custodial Care** service does not cause the service to become covered. If the **Member** is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for **Home Health Services** will only be provided during times when there is a family member or caregiver present in the home to meet the **Member's** non-skilled needs.

Skilled Nursing services that require the medical training of and are provided by a licensed nursing professional are a covered benefit. Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits. Up to 12 hours (3 visits) of continuous **Skilled Nursing** services per day

within 30 days of an inpatient **Hospital** or **Skilled Nursing Facility** discharge may be covered, when all home health care criteria are met, for transition from the **Hospital** or **Skilled Nursing Facility** to home care.

Services of a home health aide are covered only when they are provided in conjunction with **Skilled Nursing** services and directly support the **Skilled Nursing.** Services must be provided during intermittent visits of 4 hours or less with a daily maximum of 3 visits.

Medical social services are covered only when they are provided in conjunction with **Skilled Nursing** services and must be provided by a qualified social worker.

Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:

- 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.
- The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
- You are **homebound** because of **illness** or **injury**.
- The services provided are not primarily for comfort, convenience or custodial in nature.
- The services are intermittent or hourly in nature.

Outpatient home health short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Coverage is subject to the conditions and limits listed in the Short-Term Rehabilitation Therapy Services Benefit section of the **Certificate Contract** and the Short-Term Rehabilitation and Habilitation Therapy Services Benefit section of the Schedule of Benefits

Covered **Home Health Care** benefits do not include charges for infusion therapy.

Hospice Care

Covered benefits include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses
The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management;
- Respite care**;** and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses
Covered benefits include charges made on an outpatient basis by a **hospice care agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day;

- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy;
- Consultation or case management services by a **physician**;
- Medical supplies;
- **Prescription drugs**;
- Respite care;
- Bereavement counseling of the **Member's** immediate family or family caregiver of the **Member** prior to; and within 6 months after; the **Member's** death;
- Dietary counseling; and
- Psychological counseling.

Covered benefits also include charges made by the providers below if they are not an employee of a **hospice care agency**; and such agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Important Notes:
Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for details about **precertification**. Please see the *Schedule of Benefits* for any maximums that apply to *Hospice Care*.

4. Emergency Care and Urgent Care

Emergency Care/Urgent Care Benefit

1. **Emergency Care**:

   A **Member** is covered for **Emergency Services**, provided the service is a **Covered Benefit**, and **Aetna**'s review determines that a **Medical Emergency** existed at the time medical attention was sought by the **Member**.

   The **Copayment** for an emergency room visit as described on the *Schedule of Benefits* will not apply in the event that the **Member** was referred for such visit by the **Member's PCP** for services that should have been rendered in the **PCP's** office or if the **Member** is admitted into the **Hospital**.

   The **Member** will be reimbursed for the cost for **Emergency Services** rendered by a non-participating **Provider** located either within or outside the **Aetna Service Area**, for those expenses, less **Copayments**, which are incurred up to the time the **Member** is determined by **Aetna** and the attending **Physician** to be medically able to travel or to be transported to a **Participating Provider**. In the event that transportation is required, the **Member** will be reimbursed for the cost as determined by **Aetna**, minus any applicable **Copayments**. Reimbursement may be subject to payment by the **Member** of all **Copayments** which would have been required had similar benefits been provided during office hours and upon prior **Referral** to a **Participating Provider**.

   Medical transportation is covered during a **Medical Emergency**.

2. **Urgent Care**:

   Urgent Care Within the Aetna Service Area. If the **Member** needs **Urgent Care** while within the **Aetna Service Area**, but the **Member's** illness, injury or condition is not serious enough to be a **Medical Emergency**, the **Member** should first seek care through the **Member's PCP.** If the **Member's PCP** is not reasonably available to provide services for the **Member**, the **Member** may access **Urgent Care** from a **Participating Urgent Care Facility** within the **Aetna Service Area**.

   Urgent Care Outside the Aetna Service Area. The **Member** will be covered for **Urgent Care** obtained from a **Physician** or licensed facility outside of the **Aetna Service Area** if the **Member** is temporarily absent from the **Aetna Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **Aetna Service Area**.

   A **Member** is covered for any follow-up care. Follow-up care is any care directly related to the need for **Emergency Services** which is provided to a **Member** after the **Medical Emergency** or **Urgent Care** situation has terminated. All follow-up and continuing care must be provided or arranged by a **Member's PCP**. The **Member** must follow this procedure, or the **Member** will be responsible for payment for all services received.

5. Pediatric Dental Benefits

Pediatric Dental Services
Covered expenses include charges made by a **dental provider,** who is a **network provider,** for the dental services listed in the Pediatric Dental Care Schedule below and provided to covered persons through age 18.

The plan does not pay a benefit for all dental care expenses that you incur.

Important Reminder:

Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

About the HMO Dental Expense Insurance Plan

You can choose a **dental provider** who is in the dental network.

Using Network Providers

- You will receive the Plan's higher level of benefits when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge.** Your **coinsurance** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles, coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible, copayment, coinsurance**, or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Contact Member Services by logging onto the Aetna website www.aetna.com, or calling the toll-free number on the back of your ID card if you have questions regarding your statement.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract or a **network provider** may limit the number of patients accepted in a practice.

Getting an Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Important Note:

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $300. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting images and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See the *Alternate Treatment Rule* later in this amendment for more information on alternate dental procedures.)

What Is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

In Case of a Dental Emergency

If you need dental care for the palliative treatment (e.g., pain relieving, stabilizing) of a **dental emergency**, you are covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Follow the guidelines below when you believe you have a **dental emergency**.

If you have a **dental emergency**, you may get treatment from any dentist. You should consider calling your dental **network provider**, if possible. Your dental network provider may be more familiar with your dental needs. If you are not able to reach your dental **network provider** or are away from home, you may get treatment from any **dentist**. You may also call Aetna Member Services at the toll-free telephone number on your ID card for help in finding a **dentist**. The care received from a dental out-of-network provider must be for the temporary relief of the **dental emergency** until you can be seen by your dental **network provider**. Care received from a dental **out-of-network provider** for other than the temporary relief of the **dental emergency** may cost you more. To receive the maximum level of benefits, care should be provided by a dental **network provider.**

What does the Plan pay when you go to an out-of-network provider for a Dental Emergency?

The network level of coverage applies for services and supplies received from a dental out-of-network provider for the temporary relief of a dental emergency. The care provided must be a covered service or supply. You must submit a claim to **Aetna** describing the care given by an **out-of-network provider** in order to receive reimbursement. Reimbursement will be based upon the network covered amount according to the Type of dental expense, as shown in the *Schedule of Benefits*, up to the **dental emergency** maximum. You are responsible for charges above the **dental emergency** maximum.

Additional dental care to treat the dental condition after the **dental emergency** has been stabilized will be covered at the appropriate **coinsurance** level depending upon where you receive service. If you use a dental **network provider** for follow-up care, the network level of benefits applies.

The plan pays a benefit up to the dental emergency maximum for care provided by an **out-of-network provider.**

Rules and Limits That Apply to the Dental Benefits

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Orthodontic Treatment Rule

Orthodontic treatment is covered when it is **medically necessary** for a covered person until the end of the month in which the enrollee turns 19 with a fully erupted set of permanent teeth and a severe, dysfunctional, handicapping condition such as:

(A) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

(B) The following craniofacial anomalies:
- Hemifacial microsomia;
- Craniosynostosis syndromes;
- Cleidocranial dental dysplasia;
- Arthrogryposis; or
- Marfan syndrome

(C) Anomalies of facial bones and/or oral structures

(D) Facial trauma resulting in functional difficulties

Reimbursable orthodontic services include:
- pre-orthodontic treatment visit
- comprehensive orthodontic treatment
- orthodontic retention (removal of appliances, construction and placement of retainers(s)

This benefit does not cover charges for the following:
- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to **Aetna** that:
- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule
The installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule
Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Completed After Termination of Coverage
Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Pediatric Dental Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary**. Charges made for the following are not covered except to the extent listed under the *What the Medical Benefit Covers* section of the Policy or by amendment attached to the Policy. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the following exclusions that apply to medical benefits.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Medical Benefit Covers* section of the Policy.

- Any non-emergency charges for **covered expenses** incurred outside of the United States.

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in the Policy.

- Any instruction for diet and plaque control.

- Charges submitted for services:
  - By an unlicensed **hospital**, **physician** or other provider; or
  - By a licensed **hospital**, **physician** or other provider that are not within the scope of the provider's license.

- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

- **Cosmetic** services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Medical Benefit Covers* section of the Policy. Facings on molar crowns and pontics will always be considered **cosmetic**.

- Court ordered services, including those required as a condition of parole or release.

- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.

- Dental Examinations that are:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service.

- Dental implants, braces except to the extent coverage is specifically provided in the *What the Medical Benefit Covers* section of the Policy, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

- Dental services and supplies that are covered in whole or in part under any other part of this plan.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

- Except as covered in the *What the Medical Benefit Covers* section of the Policy, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- **Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Medical Benefit Covers* section of the Policy.

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **medically necessary** covered service or supply.

- Medicare: Payment for that portion of the charge for which Medicare is the primary payer.

- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a **physician's** practice;
  - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:

Care in charitable institutions;

Care for conditions related to current or previous military service;

Care while in the custody of a governmental authority;

Any care a public **hospital** or other facility is required to provide; or

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.

- Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

- **Orthodontic treatment** except as covered in the Orthodontic Treatment Rule section of the Policy.

- Pontics, crowns, cast or processed restorations made with high noble metals (gold).

- Prescribed drugs or pre-medication.

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

- Replacement of teeth beyond the normal complement of 32.

- Routine dental exams and other preventive services and supplies, except as specifically provided in this amendment and in the *What the Medical Benefit Covers* section of the Policy.

- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Services rendered before the effective date or after the termination of coverage.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Surgical removal of impacted wisdom teeth only for orthodontic reasons.

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.

- Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

6. Specific Conditions

Maternity Care and Related Newborn Care Benefit

Covered Benefits include outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by **Participating Providers**. The **Participating Provider** is responsible for obtaining any required precertification for all non-routine obstetrical services from **Aetna** after the first prenatal visit.

Coverage does not include routine maternity care (including delivery) received while outside the **Service Area** unless the **Member** receives **precertification** from **Aetna**.

As an exception to the **Medically Necessary** requirements of this **Contract**, the following coverage is provided for a mother and newly born child:

- A minimum of 48 hours of inpatient care in a **Participating Hospital** following a vaginal delivery;

- A minimum of 96 hours of inpatient care in a **Participating Hospital** following a cesarean section; or

- A shorter **Hospital** stay, if requested by a mother, and if determined to be medically appropriate by the **Participating Providers** in consultation with the mother.

If a **Member** requests a shorter **Hospital** stay, the **Member** will be covered for one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the **Participating Provider**. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A **Copayment** will not apply for home health care visits.

- Complications of Pregnancy – **Member** is covered for complications of pregnancy, including any condition which requires **Hospital** confinement for **Medically Necessary** treatment and:

    - If the pregnancy is not terminated, if caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similarly medically diagnosed condition; or,

    - If the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy, or spontaneous termination.

Reconstructive Breast Surgery Benefit

Covered Benefits include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, at least 2 prostheses, and physical therapy to treat complications for all stages of mastectomy, including lymphedema.

Reconstructive or Cosmetic Surgery and Supplies
Covered Benefits include charges made by a **Physician**, **Hospital**, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Important Note: Injuries that occur as a result of a medical (*i.e*., non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - The defect results in severe facial disfigurement, or
  - The defect results in significant functional impairment and the surgery is needed to improve function

Mental Disorders Benefit

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or **Behavioral Health Provider** for the treatment of **Mental Disorders** 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** or **Psychiatric Hospital** or **Residential Treatment Facility**, including:

  - **Partial Hospitalization Treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **Physician**. The facility or program does not make a room and board charge for the treatment.

  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **Physician**.

  - Office visits to a **Physician** (such as a **Psychiatrist**), psychologist, social worker, or licensed professional counselor, as well as other health professionals.

Substance Abuse Benefit

Covered Benefits include charges made by a **Hospital**, **Psychiatric Hospital**, **Residential Treatment Facility** or **Behavioral Health Provider** for the treatment of **Substance Abuse** 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 only when you are admitted to the **Hospital's** separate **Substance Abuse** section (or unit), for treatment of medical complications of **Substance Abuse**.

  As used here, "medical complications" include, but are not limited to, **Detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **Hospital or Psychiatric Hospital** or as part of **Partial Hospitalization Treatment**, including:

  - **Partial Hospitalization Treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **Physician**. The facility or program does not make a **room and board** charge for the treatment.

  - Intensive Outpatient Program (at least 2 hours per day and at least six hours per week of clinical treatment) provided in a facility or program under the direction of a **physician.**

  - Ambulatory detoxification –Outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications.

  - Office visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health care professionals.

Autism Spectrum Disorders Benefit

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Covered Benefits include the services and supplies for the screening, diagnosis and treatment, (including behavioral therapy and Applied Behavioral Analysis), of **Autism Spectrum Disorder**. The services and supplies must be ordered by a **Physician** or **Behavioral Health Provider.**

Coverage also includes early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Important: Applied Behavioral Analysis requires precertification by the Aetna and the Participating Provider is responsible for obtaining precertification.

Diabetes Benefit

Covered Benefits include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

- **Services and Supplies:**
  - Foot care to minimize the risk of infection;
  - Insulin preparations;
  - Diabetic needles and syringes;
  - Diabetic test agents;
  - Lancets/lancing devices;
  - Prescribed oral medications whose primary purpose is to influence blood sugar;
  - Alcohol swabs;
  - Injectable glucagons; and
  - Glucagon emergency kits.

- **Equipment:**
  - External insulin pumps; and
  - Blood glucose monitors without special features unless required due to blindness.

- **Self-Management Training:**
  - The training and education provided to you after you are initially diagnosed with diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
  - Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in your symptoms or condition which requires modification of your program of self-management of diabetes; and
  - Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

Treatment of Basic Infertility Services Benefit

Covered Benefits include only those **Infertility** services provided to a **Member**: a) by a **Participating Provider** to diagnose **Infertility**; and b) by a **Participating Infertility Specialist** to surgically treat the underlying cause of **Infertility**.

Comprehensive Infertility Benefit

To be an eligible covered female for benefits you must be covered under this **Contract**, or be a covered dependent who is the employee's legal spouse.

Even though not incurred for treatment of an illness or injury, **Covered Benefits** will include expenses incurred by an eligible covered female for **Infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **Infertility**, has been recognized and diagnosed as **Infertility**, by a gynecologist; network **Infertility Specialist**, or your **Physician**, and it has been documented in your medical records.
- The procedures are done; while not confined in a **Hospital**; or any other facility; as an inpatient.
- Your FSH levels are less than; 19 miU on day 3 of the menstrual cycle.
- The **Infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.

Comprehensive Infertility Services Benefit

If you meet the eligibility requirements above the following comprehensive infertility services expenses are payable when provided by a **Participating Infertility Specialist** upon precertification by **Aetna**, subject to the all the exclusions and limitations of this **Contract***:*

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown on the *Schedule of Benefits* and a maximum of 6 cycles per lifetime; (where lifetime is defined to include services provided or administered by **Aetna** or any affiliated company of **Aetna**; and
- Intrauterine insemination is subject to the maximum benefit, if any, shown on the *Schedule of Benefits* and a maximum of 6 cycles per lifetime; (where lifetime is defined to include services provided or administered by **Aetna** or any affiliated company of **Aetna**.

Transplant Benefit

Once it has been determined that a **Member** may require a **Transplant**, the **Member** or the **Member's Physician** must call the **Aetna** precertification department to discuss coordination of the **Transplant** process. **Covered Benefits** include non-experimental or non-investigational **Transplants** coordinated by **Aetna** and performed at an **Institute of Excellence, (IOE)**. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the **Transplant** required by the **Member**.

Covered Benefits include the following when provided by an **IOE**.

- Inpatient and outpatient expenses directly related to a **Transplant Occurrence.**
- Charges made by a **Physician** or **Transplant** team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.
- Charges for activating the donor search process with national registries.
- Charges made by a **Hospital** or outpatient facility and/or **Physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

- Related supplies and services provided by the **IOE** facility during the **Transplant** Occurrence process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; **Home Health Services** and home infusion services.
- Medical emergencies related to transplants.

Any **Copayments** or **Coinsurance** associated with **Transplants** are set forth in the ***Schedule of Benefits***. **Copayments** or **Coinsurance** apply per **Transplant Occurrence**. Coverage for transportation and lodging will be reflected on the ***Schedule of Benefits.***

One **Transplant Occurrence** includes the following four phases of **Transplant** care:

- **Pre-Transplant Evaluation/Screening**: Includes all **Transplant**-related professional and technical components required for assessment, evaluation and acceptance into a **Transplant** facility's **Transplant** program.

- **Pre-Transplant/Candidacy Screening:** Includes HLA typing of immediate family members.

- **Transplant Event:** Includes inpatient and outpatient services for all **Transplant**-related health services and supplies provided to a **Member** and donor during the one or more surgical procedures or medical therapies for a **Transplant**; **Prescription Drug**s provided during the **Member's** inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during the **Member's** inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

- **Follow-up Care:** Includes **Home Health Services;** home infusion services; and **Transplant**-related outpatient services rendered within 180 days from the date of the **Transplant.**

For the purposes of this section, the following will be considered to be one **Transplant Occurrence:**

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell **Transplant**
- Multiple organs replaced during one **Transplant** surgery
- Tandem **Transplants** (Stem Cell)
- Sequential **Transplants**
- Re-**Transplant** of same organ type within 180 days of the first **Transplant**
- Any other single organ **Transplant**, unless otherwise excluded under the coverage

The following will be considered to be <u>more than one</u> **Transplant Occurrence**:

- Autologous Blood/Bone Marrow **Transplant** followed by Allogenic Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Allogenic Blood/Bone Marrow **Transplant** followed by an Autologous Blood/Bone Marrow **Transplant** (when not part of a tandem **Transplant**)
- Re-**Transplant** after 180 days of the first **Transplant**
- Pancreas **Transplant** following a kidney **Transplant**
- A **Transplant** necessitated by an additional organ failure during the original **Transplant** surgery/process.
- More than one **Transplant** when not performed as part of a planned tandem or sequential **Transplant,** (e.g. a liver **Transplant** with subsequent heart **Transplant**).

7. Specific Therapies and Tests

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Benefit

Covered Benefits include charges made on an outpatient basis by a **Physician**, **Hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging, including Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work

Covered Benefits include charges for lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The charges must be made by a **Physician**, **Hospital** or licensed radiological facility or lab.

Important Reminder:
Refer to the *Schedule of Benefits* for details about any cost-sharing or benefit maximums that may apply to outpatient diagnostic testing, lab services and radiological services.

Outpatient Diagnostic Radiological Services

Covered Benefits include charges for radiological services (other than complex imaging services), provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **Physician**. The services must be provided by a **Physician**, **Hospital** or licensed radiological facility.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **Covered Benefits** include charges made for tests performed by a **Hospital**, **Physician** or licensed diagnostic laboratory provided the charges for the surgery are **Covered Benefits** and the tests are:

- Related to your surgery, and the surgery takes place in a **Hospital**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **Hospital**;
- Not repeated in or by the **Hospital** where the surgery will be performed.
- Test results should appear in your medical record kept by the **Hospital** where the surgery is performed.

Benefit Limitations:
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder:
Complex Imaging testing for preoperative testing is covered under the *Diagnostic Complex Imaging Expense* section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Genetic Disease Testing Services
Covered Benefits include **Medically Necessary** Genetic Disease Testing, when: such testing is prescribed following the **Member**'s history, physical examination and pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, and a definitive diagnosis remains uncertain and a genetic disease diagnosis is suspected, and;

- The **Membe**r displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered to the **Member**.

Clinical Trial Therapies (Experimental or Investigational)

Covered Benefits include charges made by a provider for **Experimental or Investigational** drugs, devices, treatments or procedures, "under an approved clinical trial" only when you have cancer or a terminal illness and ***all*** of the following conditions are met:

- You have been diagnosed with cancer, chronic fatigue syndrome, or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in "an approved clinical trial" that meets these criteria.

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

- The FDA has approved the drug, device, treatment or procedure to be investigated or 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; and
- You are treated in accordance with the protocols of that study.

The clinical trial or study is conducted in the State of Nevada; and

The **Member** has signed, before the **Member's** participation in the clinical trial or study, a statement of consent indicating that the **Member** has been informed of, without limitation:

- The procedure to be undertaken;
- Alternative methods of treatment; and
- The risks associated with participation in the clinical trial or study, including, without limitations, the general nature and extent of such risks.

Clinical Trials (Routine Patient Costs)

Covered Benefits include "routine patient costs" furnished to you in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer, chronic fatigue syndrome, 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 (which may include funding through in-kind contributions) 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 in the entities listed 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.

  - Any of the following:
    The Department of Veterans Affairs.

    The Department of Defense.

    The Department of Energy.

  If the study or investigation has been reviewed and approved through a system of peer review that the federal Secretary of Health and Human Services determines:
  - To be comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
  - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug

application.

Unless the following medical treatment is provided by the sponsor of the clinical trail or study free of charge to the **Member**, charges for covered medical expenses incurred by a **Member** or covered dependent for:

- the initial consultation to determine whether the **Member** is eligible to participate in the clinical trial or study;
- any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the **Member**;
- health care services for the appropriate monitoring of the **Member** during an approved clinical trial or study;
- the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in an approved clinical trial or study or as a result of any complication arising out of the medical treatment provided in an approved clinical trial or study, to the extent that such health care service would otherwise be covered under the policy of health insurance;
- the cost of any routine health care services that would otherwise be covered under the policy of health insurance for a **Member** participating in an approved clinical trial or study; and
- health care services for the appropriate monitoring of the **Member** during an approved clinical trial or study and which are not directly related to the clinical trial or study;

are payable on the same basis as any disease or illness covered under this Plan.

Any care provided in the approved clinical trial must be for services that are considered covered medical expenses under this Plan. They must be consistent with all of the terms and conditions of this Plan including but not limited to:

- Aetna's Clinical Guidelines and Utilization Review criteria; and
- Quality Assurance program.

Members and covered dependents are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to: precertification and referral requirements.

Not covered under this Plan are:

- 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 the **Member**; and
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising **experimental** or **investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Important Notes:
1. Refer to the *Schedule of Benefits* for details about cost sharing and any benefit maximums that apply to the *Clinical Trial* benefit. 2. These *Clinical Trial* benefits are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to, any **precertification** and

referral requirements.

Outpatient Therapies

Infusion Therapy Benefit

Covered Benefits include infusion therapy you receive in an outpatient setting. An outpatient setting includes but is not limited to:

- A free-standing outpatient facility
- The outpatient department of a **Hospital**
- A **Physician** in his/her office or in your home

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.

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

Infusion therapy is the intravenous or continuous administration of medications or solutions that are **medically necessary** for your course of treatment. Charges for the following outpatient infusion therapy services and supplies are **covered expenses**:

- Pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes, and other additives).

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

Specialty care prescription drugs

Covered expenses include **specialty care prescription drugs** when they are:

- Purchased by the **Member's Provider,** and
- Injected or infused by the **Member's Provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **Hospital**
  - A **Physician** in his/her office

- A home care **Provider** in the **Member's** home
- And, listed on our **specialty care prescription drug** list as covered under this certificate.

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

Chemotherapy

Covered Benefits include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **Hospitalization** for chemotherapy is limited to the initial dose while **Hospitalized** for the diagnosis of cancer and when a **Hospital** stay is otherwise covered based on your health status.

Radiation Therapy Benefit

Covered Benefits include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

8. Short-term Rehabilitation Therapies Services Benefit

Covered Benefits include the following when rendered by **Participating Providers** upon **Referral** issued by the **Member's PCP** and **Precertified** by **Aetna.**

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A course of outpatient cardiac rehabilitation appropriate for your condition is covered for a cardiac condition that can be changed.

  The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a **Physician**.

- Pulmonary rehabilitation benefits are available as part of a **Member's** inpatient **Hospital** stay. A course of outpatient pulmonary rehabilitation appropriate for your condition is covered for the treatment of reversible pulmonary disease states.

Cognitive Therapy, Physical Therapy, Occupational Therapy, and Speech Therapy Rehabilitation Benefits

Covered Benefits include charges for short-term rehabilitation therapy services, as described below, when prescribed by a **Physician** up to the benefit maximums listed on your *Schedule of Benefits*. 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**; or
- A **Physician**.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. For inpatient rehabilitation benefits for the services listed below, refer to the Inpatient Hospital and Skilled Nursing Facility benefits provision under the **Covered Benefits** section of this **Contract**.

Physical therapy is covered provided the therapy is expected to:

- Significantly improve, develop or restore physical functions lost; or
- Improves any impaired function as a result of an acute illness, injury or surgical procedure.

Physical therapy does not include educational training.

Occupational therapy, (except for vocational rehabilitation or employment counseling), is covered provided the therapy is expected to:

- Significantly improve, develop or restore physical functions lost as a result of an acute illness, injury or surgical procedure; or
- Improve an impaired function as a result of an acute illness, injury or surgical procedure; or
- To relearn skills to significantly improve independence in the activities of daily living.

Occupational therapy does not include educational training.

Speech therapy is covered provided the therapy is expected to:

- Significantly improve or restore the speech function or correct a speech impairment resulting from illness, injury or surgical procedure; or
- Improve delays in speech function development as a result of 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 is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is coordinated with **Aetna** as part of a treatment plan intended to restore previous cognitive function.

Spinal Manipulation Care Benefit

Covered Benefits include services provided by a **Participating Provider** upon prior **Referral** issued by the **PCP**. Services must be consistent with **Aetna** guidelines for spinal manipulation to correct a muscular skeletal problem which could be documented by diagnostic x-rays performed by a **Participating** radiologist.

Habilitation Therapy Treatment
Covered Benefits 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**

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

- Details the treatment, and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are homebound.

Outpatient Physical, Occupational, and Speech Therapy

Covered Benefits under **Habilitation Therapy Treatment** include:

- Physical therapy, if it is expected to:
    - Develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
    - Develop any impaired function, or
    - Relearn skills to significantly develop your independence in the activities of daily living
- Speech therapy is covered provided the therapy is expected to:
    - Develop speech function as a result of delayed development

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

9. **Other Covered Benefits**

Administration of Blood and Blood Products

Covered Benefits include the administration of blood and blood products but not the cost of blood or blood products.

Ambulance Service

Covered Benefits include charges made by a professional **Ambulance**, as follows:

Ground Ambulance

Covered Benefits include charges for transportation:

- To the first **Hospital** where treatment is given in a medical emergency.
- From one **Hospital** to another **Hospital** in a medical emergency when the first **Hospital** does not have the required services or facilities to treat your condition.
- From **Hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **Hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a **Hospital**, **Skilled Nursing Facility** or acute rehabilitation **Hospital**, an **Ambulance** is required to safely and adequately transport you to or from inpatient or outpatient treatment.

Air or Water Ambulance

Covered Benefits include charges for transportation to a **Hospital** by air or water **Ambulance** when:

- Ground **Ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **Hospital** to another **Hospital**; when the first **Hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **Hospital**; and the two conditions above are met.

Benefit Limitations:
Not covered under this benefit are charges incurred to transport you:

- If an **Ambulance** service is not required by your physical condition; or
- If the type of **Ambulance** service provided is not required for your physical condition; or
  By any form of transportation other than a professional **Ambulance** service; or
- Fixed wing air **Ambulance** from an out-of-network **provider**

Anesthesia and hospital charges for dental care

Covered Benefits include facility charges and anesthesia for dental care only if you:

- Have a disability or a physical, mental, or medical condition that requires that a dental procedure be done in a hospital or other facility
- Are developmentally disabled
- Is extremely uncooperative, unmanageable, or anxious
- Has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation

Bariatric Surgery

Covered Benefits for the treatment of **morbid obesity** include one bariatric surgical procedure, per lifetime, including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for:

- Weight control services including medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Policy.

Durable Medical Equipment (DME) Benefit

Covered Benefits include **Durable Medical Equipment** when **Precertified** by **Aetna**. The wide variety of **Durable Medical Equipment** and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the **Aetna** Medical Director has the authority to approve requests on a case-by-case basis. Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this **Contract**. **Aetna** reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Instruction and appropriate services required for the **Member** to properly use the item, such as attachment or insertion, is also covered upon precertification by **Aetna**. Replacement, repairs and maintenance are covered only if it is demonstrated to the **Aetna** that:

- It is needed due to a change in the **Member's** physical condition; or
- It is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a **Member's** responsibility.

Hearing Aid Benefit

Covered Benefits include charges for hearing exams, prescribed hearing aids and hearing aid expenses as described below. This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing; and
- Parts, attachments or accessories.

Covered Benefits include the following:

- Charges for an audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A **Physician** certified as an otolaryngologist or otologist; or
  - An audiologist who (1) is legally qualified in audiology; or (2) 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.
- Charges for electronic hearing aids, installed in accordance with a **Prescription** written during a covered hearing exam;
- Any other related services necessary to access, select and adjust or fit a hearing aid.

Covered Benefits for hearing aids will not include per 48 consecutive month period:
- Charges for more than one hearing aid per ear; and
- Charges in excess of any maximum amount shown on the *Schedule of Benefits*.

Hearing Aids Alternate Treatment Rule
Sometimes there are several types of hearing aids that can be used to treat a medical condition, all of which provide acceptable results. When alternate hearing aids can be used, the plan's coverage may be limited to the cost of the least expensive device that is:
- Customarily used nationwide for treatment, and
- Deemed by the medical profession to be appropriate for treatment of the condition in question. The device must meet broadly accepted standards of medical practice, taking into account your physical condition.

You should review the differences in the cost of alternate treatment with your **Physician**. Of course, you and your **Physician** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

This *Alternate Treatment Rule* provision will not operate to deny benefits as mandated by any applicable state statute or regulation.

Benefit Limitations:
No benefits are payable under this benefit for charges incurred for:
- A service or supply which is received while the person is not a covered person under this **Contract**;
- A replacement of:
  - A hearing aid that is lost, stolen or broken; or
  - A hearing aid installed within the prior 12 month period.
- Replacement parts or repairs for a hearing aid;
- Batteries or cords;
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss:
- Any ear or hearing exam performed by a **Physician** who is not certified as an otolaryngologist or otologist;
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;

- Any hearing care service or supply which is a **Covered Benefits** in whole or in part under any other part of this Plan;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any hearing exam:
  - Required by an employer as a condition of employment; or
  - Which an employer is required to provide under a labor agreement; or
  - Which is required by any law of government.
- Hearing exams given during a stay in a **Hospital** or other facility, except those provided to newborns as part of the overall **Hospital** stay; and
- Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

Benefits after Termination of Coverage
This section applies only if a person's coverage terminates while the person is not "totally disabled" as defined in the Health Expense Benefits After Termination section.

Expenses incurred for hearing care with 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if:

- The prescription for the hearing aid was written; and
- The hearing aid was ordered;

during the 30 days before the date coverage ends.

Hormone Replacement Therapy
Covered Benefits include charges for outpatient services, and drugs and devices which are lawfully prescribed or ordered and which have been approved by the Food and Drug Administration, incurred in connection with hormone replacement therapy.

Jaw Joint Disorder Treatment including Temporomandibular Joint Syndrome Disorder
Covered Benefits include charges made by a **Physician**, **Hospital** or surgery center for the diagnosis and surgical treatment of jaw joint disorder. A jaw joint disorder is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Covered Benefits include services pre-authorized by **Aetna** for:

- Oral Surgery, limited to bony impactions of teeth, bone fractures, removal of tumors and orthodontogenic cysts or other pre-approved surgical procedures
- All other **Medically Necessary** procedures for the treatment for temporomandibular joint dysfunction

Medically Necessary procedures do not include dental procedures including but not limited to the extraction of teeth and the application of orthodontic devices and splints.

Unless specified above, not covered under this benefit are charges for dental procedures including but not limited to the extraction of teeth and the application of orthodontic devices and splints.

Nutritional Supplements Benefit (includes the treatment of inherited metabolic diseases)

Covered Benefits include charges incurred for nutritional supplements (formulas) as needed for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria including inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat as administered under the direction of a **Physician**.

As used in this section:

- "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

- "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

Prosthetic Appliances Benefit

Covered benefits include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered benefits** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of disease or **injury** or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered benefits also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;

- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

Vision Care Benefits

Pediatric Routine Vision Exams
Covered Benefits include charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction and glaucoma testing.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

Pediatric Vision Care Services and Supplies
Covered Benefits include charges for the following vision care services and supplies:

- Eyeglass frames, **Prescription** lenses or **Prescription** contact lenses identified by a vision **Participating Provider**.

Coverage includes charges incurred for:

- Non-conventional **Prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic **Prescription** lenses prescribed after cataract surgery has been performed. Low vision services.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

A listing of the locations of the vision **Participating Providers** under this Plan can be accessed at the www.aetna.com website. Be sure to look at the appropriate vision **Participating Provider** listing that applies to your plan, since different **Aetna** plans use different networks of providers. You must present your ID card to the vision **Participating Provider** at the time of service.

This benefit is subject to the maximums shown on the Schedule of Benefits. As to coverage for **Prescription** lenses in a calendar year, this benefit will cover either **Prescription** lenses for eyeglass frames or **Prescription** contact lenses, but not both. **Exception:** When an aphakic lens is prescribed after cataract surgery, we will cover eyeglass frames in addition to the lens.

Benefit Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies:

- 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.

Benefits for Vision Care Services and Supplies After Your Coverage Terminates

If your coverage under this Plan terminates while you are not totally disabled**, Covered Benefits** under this Plan will include charges that you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in prescription.

Important Notes:
Refer to the *Schedule of Benefits* for any cost-sharing, age limits, exam frequency limits and maximums that apply to vision exams, services and supplies.

EXCLUSIONS AND LIMITATIONS

Medical Exclusions

The following are not **Covered Benefits** except as described in the **Covered Benefits** section of this **Contract** or by amendment(s) attached to this **Contract**:

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

- Behavioral health services that are not primarily aimed at treatment of illness, injury, restoration of physiological functions or that do not have a physiological basis.

- Biofeedback, except as precertified by **Aetna**.

- Blood and blood plasma, including but not limited to, provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis or plasmapheresis. Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.

- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to, mental illness commitments.

- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

- Certain **Transplant Occurrence**-related services or supplies including**:** treatment furnished to a donor when the **Transplant** recipient is not a **Member**; services and supplies not obtained from an **IOE**, including the harvesting or storage of organs without the expectation of immediate transplantation for an existing illness; harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; outpatient **Prescription Drug**s not expressly related to an outpatient **Transplant** Occurrence; and home infusion therapy.

- Clinical trial therapies
  - 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

- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) **Transplants** unless authorized by **Aetna**.

- Contraception, except as specifically described in the ***Covered Benefit*** section including, but not limited to, over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

- Cosmetic Surgery, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be **Medically Necessary** by an Aetna Medical Director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

- Court ordered services, or those required by court order as a condition of parole or probation.

- **Custodial Care.**

- Dental services except as specifically covered in the ***Covered Benefits*** section, including but not limited to, 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, alveolectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include bone fractures, removal of tumors, and orthodontogenic cysts.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a **Member**, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- Experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by **Aetna**, unless precertified by **Aetna**.

  This exclusion will not apply with respect to drugs:

  - That have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
  - **Aetna** has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

- Foot Orthotics.

- Hair analysis.

- Hearing aids. Related services and supplies, except as specifically described in this **Contract**

- Home births.

- Home uterine activity monitoring.

- Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a **Member's** house or place of business, and adjustments made to vehicles.

- Hypnotherapy, except when precertified by **Aetna**.

- Implantable drugs.

- Infertility. Any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, such as:

  - Drugs, and drugs related to the treatment of non-**covered benefits**.
  - Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
  - Reversal of voluntary sterilization including related procedures, services and supplies.
  - The purchase of donor sperm and any charges for the storage of sperm.
  - 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.
  - Home ovulation prediction kits or home pregnancy tests.
  - Medication that is **Experimental or Investigational** in relation to **infertility**.
  - The purchase of donor embryos, donor oocytes, or donor sperm.
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.), including thawing charges.
  - All charges associated with 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.
  - All charges associated with 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.
  - **ART services.**
  - Any charges associated with obtaining sperm for **ART services.**
  - Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.

- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intra-fallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

- Military service related diseases, disabilities or injuries for which the **Member** is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the **Member**.

- Missed appointment charges.

- Non-**Medically Necessary** services, including but not limited to, those services and supplies:

  - Which are not **Medically Necessary**, as determined by **Aetna**, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;
  - That do not require the technical skills of a medical, mental health or a dental professional;
  - Furnished mainly for the personal comfort or convenience of the **Member**, or any person who cares for the **Member**, or any person who is part of the **Member's** family, or any **Provider**;
  - Furnished solely because the **Member** is an inpatient on any day in which the **Member's** disease or injury could safely and adequately be diagnosed or treated while not confined;
  - Furnished solely because of the setting if the service or supply could safely and adequately be furnished in a **Physician's** or a dentist's office or other less costly setting.

- Nursing and aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

- Outpatient infusion therapy services, other than as specifically described in the ***Covered Benefits*** section, including:
  - Enteral nutrition
  - Blood transfusions and blood products
  - Dialysis

- Outpatient **Prescription** contraceptive drugs and devices services, other than as specifically described in the *Covered Benefits* section, including:

  - Oral drugs that are **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.
  - Injectable drugs that are **brand-name Prescription Drugs** and **biosimilar Prescription Drugs**.

- Outpatient supplies, including but not limited to, medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.

- Payment for that portion of the benefit for which Medicare or another party is the primary payer.

- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone

charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.

- Prescription or non-**Prescription Drug**s and medicines, except as provided on an inpatient basis.

- Recreational, educational, and sleep therapy, including any related diagnostic testing.

- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

- Routine foot/hand care, including routine reduction of nails, calluses and corns.

- Services for which a **Member** is not legally obligated to pay in the absence of this coverage**.**

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of the **Member's** coverage, unless coverage is continued under the Continuation and Conversion section of this **Contract**.

- Services performed by a relative of a **Member** for which, in the absence of any health benefits coverage, no charge would be made.

- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.

  Services which are not a **Covered Benefit** under this **Contract**, even when a prior **Referral** has been issued by a **PCP**.

- Short-Term Rehabilitation Services -- Outpatient Cognitive Rehabilitation, Physical, Occupational and Speech Therapy
  Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

  Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:

- Down syndrome
- Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Specific injectable drugs, including:

  - Experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH);
  - Needles, syringes and other injectable aids, except for diabetic supplies and aids;
  - Drugs related to the treatment of non-covered services; and
  - Drugs related to the treatment of **Infertility** and performance enhancing steroids.

  Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- **Telemedicine** Non-Contracting **Providers:** Any services that are given by **providers** that are not contracted with **Aetna** as **Telemedicine providers.** Any services that are not provided during an internet-based consult or via telephone.

- Tobacco Use: 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).

- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

- Thermograms and thermography.

- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

- Treatment of intellectual disability, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of intellectually disabled **Members** in

accordance with the benefits provided in the **Covered Benefits** section of this **Contract**.

- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a Workers' Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational" regardless of cause.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without a **Referral** issued by the **Member's PCP** or precertified by **Aetna**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Unauthorized services obtained by the **Member** that require precertification by **Aetna** including but not limited to **Hospital** admissions and outpatient surgery. **Participating Providers** are responsible for obtaining precertification of **Covered Benefits** from **Aetna**.

- Vision: Vision-related services and supplies, except as described in the ***Covered Benefits*** section.

  In addition, the plan does not cover:

  - Special supplies such as non-**Prescription** sunglasses;
  - Vision service or supply which does not meet professionally accepted standards;
  - Special vision procedures, such as orthoptics or vision training;
  - 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.

- Weight control services including medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **Morbid Obesity**, or for the purpose of weight reduction**,** regardless of the existence of comorbid conditions except as provided by this **Contract**.

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

- Acupuncture and acupuncture therapy, except when performed by a **Participating Physician** as a form of anesthesia in connection with covered surgery.

- Non-surgical treatment of temporomandibular joint disorder (TMJ)

- Voluntary termination of pregnancy.

Limitations

- In the event there are 2 or more alternative **Medical Services** which in the sole judgment of **Aetna** are equivalent in quality of care, **Aetna** reserves the right to provide coverage only for the least costly **Medical Service**, as determined by **Aetna**, provided that **Aetna** pre-authorizes the **Medical Service** or treatment.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this **Contract** are at the discretion of **Aetna,** subject to the terms of this **Contract**.

Outpatient Prescription Drugs

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna Prescription Drug** plan. This **Contract** explains:

- How to access **Network Pharmacies** and procedures you need to follow;
- What **Prescription Drug** expenses are covered and what limits may apply;
- What **Prescription Drug** expenses are not covered by the plan;
- How you share the cost of your covered **Prescription Drug** benefit; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **Prescription Drug** plan pays benefits only for **Prescription Drug** expenses described in this **Contract** as **Covered Benefits**.
- This **Contract** applies to coverage only and does not restrict your ability to receive **Prescription Drugs** that are not or might not be covered benefits under this **Prescription Drug** plan.
- Store this **Contract** in a safe place for future reference.

Notice
The plan does not cover all **Prescription Drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your **Contract**.

- **Covered Benefits** are subject to cost sharing requirements as described in the cost sharing sections of this coverage and in your *Schedule of Benefits*.
- **Specialty Prescription Drug** refills will only be covered when obtained through **Aetna's Specialty Network Pharmacy**.

This plan covers only certain **Prescription Drugs** in accordance with the plan that you elected and the **Preferred Drug Guide (Formulary)**. This plan does not cover all **Prescription Drugs**.

Accessing Pharmacies and Benefits

This plan provides access to **Covered Benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **Network Pharmacies** to provide **Prescription Drugs** and other supplies to you.

Obtaining your benefits through **Network Pharmacies** has many advantages. Benefits and cost sharing may vary by the type of **network pharmacy** where you obtain your **Prescription Drug** and whether or not you purchase a:

- **Generic prescription drug**;
- **Brand-name prescription drug**;
- **Biosimilar prescription drug**;

- **Preferred drug**;
- **Non-preferred drug**;
- **Self-injectable drug**; or
- **Specialty care drug;** or
- **Tier 1A prescription drug**.

To better understand the choices that you have with your plan, please carefully review the following information.

Accessing Network Pharmacies and Benefits

You may select a designated **Network Pharmacy** from the **Aetna** on-line Directory or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of designated **Network Pharmacies**. If you cannot locate a designated **Network Pharmacy** in your area call Member Services.

You must present your ID card to the designated **Network Pharmacy** every time you get a **Prescription** filled to be eligible for designated network **Covered Benefits**. The designated **Network Pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the designated **Network Pharmacy**.

You do not have to complete or submit claim forms. The designated **Network Pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **Prescription** filled in an emergency or **Urgent Care** situation, or when you are traveling, you can obtain network benefits by filling your **Prescription** at any designated **Network Retail Pharmacy**. The designated **Network Pharmacy** will fill your **Prescription** and only charge you your plan's cost sharing amount.

If you access a **Non-Participating Pharmacy** you will pay the full cost of the prescription and will need to file a claim for reimbursement. You will be reimbursed for your **Covered Benefits** up to the cost of the **Prescription** less your plan's cost sharing for network benefits.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **Pharmacy**. Either **Aetna** or any **Network Pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits; refer to the Schedule of Benefits for details.

- You will be responsible for the **Copayment, if any,** for each **Prescription** or refill as specified in the *Schedule of Benefits*. The **Copayment,** if applicable, is payable directly to the **Network Pharmacy** at the time the **Prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

What the Pharmacy Benefit Covers

The plan covers charges for outpatient **Prescription Drugs** for the treatment of an illness or injury, including drugs and devices for contraception and for hormone replacement therapy, subject to the Limitations section of this coverage and the *Medical Benefit* and *Pharmacy Benefit* Exclusions sections of the **Contract**. Prescriptions must be written by a prescriber licensed to prescribe federal legend **Prescription Drug**s.

This plan covers only certain preferred, non-preferred, generic, tier 1A **Prescription Drugs** in accordance with the plan that you elected and the **Preferred Drug Guide (Formulary)**. This plan does not cover all **Prescription Drugs**.

You may minimize your out-of-pocket expenses by selecting a **Generic Prescription Drug** when available.

Prescription drugs that are not listed on the **Preferred Drug Guide (Formulary)** are excluded from coverage unless a medical exception is approved by **Aetna**. Refer to the *Medical Exceptions* described below for details. In order for you to use a **Prescription Drug** not on the **Preferred Drug Guide (Formulary)**, you or your prescriber must request coverage as a medical exception.

If we approved a **prescription drug** for a medical condition for you and the drug is no longer in our current **Preferred Drug Guide (Formulary)**, we must cover the drug if:

- The **prescriber** determines after a reasonable investigation that none of the currently approved drugs are medically appropriate for you.
- The drug is appropriately prescribed and considered safe and effective for treating your medical condition.

Your **Prescription Drug** benefit may be subject to pharmacy management programs including, but not limited to **Precertification, Step Therapy,** quantity limits and drug utilization review. Refer to *Understanding Pharmacy Precertification* for further information.

Your **Prescription Drug** benefit includes coverage for a **Prescription Drug** that is necessary for a member to prevent the rejection of a transplanted organ. If our **Preferred Drug Guide (Formulary)** changes, you and your **Prescriber** will be notified 30 days prior to the change in our **Formulary.**

Prescription Drugs covered by this plan are subject to drug and narcotic utilization review by **Aetna**, your **Provider** and/or your **Network Pharmacy**. This may include limiting access of **Prescription Drugs prescribed** by a specific **Provider**. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for **Covered Benefits.**

Orally administered anti-cancer drugs, including chemotherapy drugs

Orally administered anti-cancer drugs, including chemotherapy drugs may be covered when the drug 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.

Retail Pharmacy Benefit

Outpatient **Prescription Drugs** are covered when dispensed by a retail **pharmacy**. Each **Prescription** is limited to the maximums shown in the *Schedule of Benefits***.**

Mail Order Pharmacy Benefit

Outpatient **Prescription Drugs** are covered when dispensed by a mail order pharmacy that is a **Network Pharmacy**. Each **Prescription** is limited to a maximum supply when filled at a mail order **Pharmacy** that is a **Network Pharmacy**. The maximums are shown in the *Schedule of Benefits.*

The plan will not cover outpatient **prescription drugs** received through a **mail order** pharmacy that is an **out-of-network** pharmacy**.**

See the *Schedule of Benefits* for details on supply limits and cost sharing.

Specialty Care Prescription Drug Benefit
Specialty Care Prescription Drugs (Specialty Care Drugs) are covered only when dispensed through a retail **Network Pharmacy** or a **Specialty Network Pharmacy**. **Specialty care 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. Refer to **Aetna's** website, www.aetna.com to review the list of covered **Specialty Care Prescription Drugs.**

You are required to obtain **Specialty Care Prescription Drugs** at a **Specialty Network Pharmacy** for all **Prescription Drug** initial fills and refills except in urgent situations.

Over-the-Counter Drugs

Over-the-counter medications, as determined by the plan may be covered in an equivalent prescription dosage strength for the **Non-Preferred**, **Preferred, Generic Tier 1A, Brand-name** appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto www.aetna.com.

Other Covered Pharmacy Benefits

The following **Prescription Drugs**, medications and supplies are also **Covered Benefits** under this Coverage.

Off-Label Use

U.S. Food and Drug Administration (FDA) approved **Prescription Drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s) subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information);
  - Thomson Micromedex DrugDex System (DrugDex);
  - Clinical Pharmacology (Gold Standard, Inc.); or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial. 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 symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above; or
  - The dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Coverage of off-label use of these drugs may, in Aetna's discretion, be subject to **Precertification**, **Step Therapy** or other requirements or limitations.

Diabetic Supplies

Covered Expenses include but are not limited to the following diabetic supplies upon **Prescription** by a **Physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered Benefits include charges made by a **Pharmacy** for the following contraceptive methods when prescribed by a prescriber and the **Prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **Prescription drugs** including emergency contraceptives that are included on the **Preferred Drug List (Formulary)**.
- Female contraceptive devices.
- FDA –approved female generic and brand-name over-the-counter (OTC) contraceptives: Coverage is limited to one per day and a 30-90 day supply per prescription.

Benefits are payable under your medical or **Pharmacy** benefit depending on the type of expense and how and where the expense is incurred. Benefits are payable under your medical plan when charges are made by a **Physician** to insert or remove a **Prescription** drug or device.

Important Note:
This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Refer to your *Schedule of Benefits* for the *Female Contraceptives - Copayment and Deductible Waiver* provision for cost-sharing information.

Oral Infertility Drugs

The following **Prescription Drugs** used for the purpose of treating infertility including, but not limited to Progesterone.

Understanding Pharmacy Precertification

Precertification is required for certain outpatient **Prescription Drugs**. prescriber**s** must contact **Aetna** or an affiliate to request and obtain coverage for such **Prescription Drugs**. The list of drugs requiring **Precertification** is subject to periodic review and modification by **Aetna**. For the most up to date information, call the toll-free Member Services number on your ID card or log on to your Aetna Navigator secure member website at www.aetna.com.

How to Obtain Precertification

If an outpatient **Prescription drug** requires **Precertification** and you use a **Network Pharmacy** the prescriber is required to obtain **Precertification** for you.

Aetna will let your prescriber know if the **Prescription Drug** is **Precertified**.

If **Precertification** is denied **Aetna** will notify you how the decision can be appealed.

Step Therapy

Step Therapy is another form of **Precertification**. With **Step Therapy**, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the prescriber obtains a medical exception.

Lists of the **Step Therapy** drugs and prerequisite drugs are included in the **Preferred Drug Guide (Formulary)** available upon request or on your Aetna Navigator secure member website at www.aetna.com. The list of step therapy drugs are subject to change by **Aetna**.

Prescribing Units

Depending on the form and packing of the product, some **Prescription Drugs** are limited to 100 units excluding insulin dispensed per **Prescription** order or refill. Drugs that are allowed to be filled with greater than a 30 day supply at a **Retail Pharmacy** are excluded from the 100 unit limitation dispensed per **Prescription** order or refill.

Any **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**.

Specialty Care Prescription Drugs may have limited access or distribution and are limited to no more than a 30 day supply subject to supply limits.

Medical Exceptions

Your prescriber may seek a medical exception to obtain coverage for drugs not listed on the **Preferred Drug Guide (Formulary)** or for which coverage is denied through **Precertification**. The prescriber must submit such exception requests to **Aetna**. Coverage granted as a result of a medical exception shall be based on an individual, case by case **Medical Necessity** determination and coverage will not apply or extend to other covered persons. If approved by **Aetna**, you will receive the non-preferred **network** benefit level as shown in your *Schedule of Benefits*

You, your designee or your prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An exigency exists when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. You, your designee, or your prescriber may submit a request for an expedited review for an exigency as described below by contacting **Aetna's** *Precertification Department* at 1-855-582-2025, faxing the request to 1-855-330-1716 or submitting the request in writing to Aetna PA 1300 E Campbell Road Richardson, TX 75081. We will make a coverage determination within 24 hours after receipt of your request and will notify you or your designee and your prescriber of our decision.

Pharmacy Benefit Limitations and Exclusions

Limitations

A **Network Pharmacy** may refuse to fill a **Prescription** order or refill when in the professional judgment of the pharmacist the **Prescription** should not be filled.

The plan will not cover expenses for any **Prescription Drug** for which the actual charge to you is less than the required **Copayment** or **Deductible**, if any, or for any **Prescription Drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in make reimbursement determinations subject to the Complaint and Appeals section(s) of the **Contract**.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **Copayments** you are responsible for per vial of Depo-Provera and/or Medroxyprogesterone, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **Prescription Drug** dispensed by a mail order **Pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Compounded **prescriptions** will be subject to **non-preferred** cost sharing.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin vials, pens, cartridges, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill. Drugs that are allowed to be filled with greater than 30 day supply at a **retail pharmacy** are limited to 300 units dispensed per **prescription** order or refill.

Any **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**.

Specialty care prescription drugs may have limited access or distribution and are limited to no more than a 30 day supply.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **contract year**.

Prescribed contraceptive diaphragms are limited to two (2) per **contract year**.

Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **Physician** it may not be covered. The plan covers only those services and supplies that are included in the ***Covered Benefits*** section. Charges made for the following are not covered except to the extent listed under the ***Covered Benefits*** section or by amendment attached to this **Contract**. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **Prescription Drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

- Abortion drugs.
- Administration or injection of any drug.
- All drugs or medications in a **therapeutic drug class** if one of the drugs in that **Therapeutic Drug Class** is not a **Prescription Drug**, unless **Medically Necessary**.
- Allergy sera and extracts.
- Any charges in excess of the benefit, day, or supply limits stated in this **Contract**.
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **Prescription Drugs**, or supplies, even if otherwise covered under this **Contract**. This also includes **Prescription Drugs** or supplies if:
  - Such **Prescription Drug** or supplies are unavailable or illegal in the United States; or
  - The purchase of such **Prescription Drugs** or supplies outside the United States is considered illegal.
- Any drugs or medications, services and supplies that are not **Medically Necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your **Physician.**
- Any **Prescription Drug** or supply used for the treatment of sexual dysfunction/ enhancement in any form. Any **Prescription Drug** in any form that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar or identical outcomes.
- **Brand-name Prescription Drugs** and devices when a preferred, non-preferred, **Generic, tier 1A, tier Prescription Drug** or device equivalent, **Biosimilar Prescription Drug** or preferred, non-preferred, **Generic**, tier 1A, **Prescription Drug** or device alternative is available, unless otherwise covered by medical exception.
- Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.
- Certain **Prescription Drugs** but only to the extent such coverage is excluded under the plan that you elected and the **Preferred Drug Guide (Formulary)**.
- Contraceptives, except as specifically described in the *What the Pharmacy Benefit Covers* section including, but not limited to, over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

- Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth and removal, including but not limited to:

  - Health and beauty aids;
  - Chemical peels;
  - Dermabrasion;
  - Treatments;
  - Bleaching;
  - Creams;
  - Ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

- Compounded prescriptions.

- Devices and appliances that do not have the National Drug Code (NDC).

- Dietary supplements including medical foods.

- Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

- Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

- Drugs that include vitamins and minerals, both over-the counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

- Drugs used for methadone maintenance medications used for drug detoxification.

- Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

- Drugs or medications that include the same active ingredient or a modified version of an active ingredient and:
  - Is therapeutically equivalent or therapeutically alternative to a covered **Prescription Drug** (unless medical exception is approved), or
  - Is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless medical exception is approved).

- Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

- Drugs, services and supplies given in connection with treatment of an occupational injury or occupational illness.

- Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the ***Covered Benefits*** section.

- Drugs 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; and
  - Other medications.

- Drugs used for the treatment of obesity.

- Drugs used for the treatment of sexual dysfunction/enhancement.

- All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

- Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

- A drug or medication that is therapeutically equivalent or therapeutically alternative to a covered prescription drug.

- A drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

- Duplicative drug therapy (e.g. two antihistamine drugs).

- **Durable medical equipment**, monitors and other equipment except as described in the *Covered Benefits* section.

- **Experimental or Investigational** drugs or devices, except as described in the *Covered Benefits* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This limitation will not apply to formulas and special modified food products as specifically stated in this **Contract**.

- Genetics: Any treatment, device, drug, 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.

- Immunization or immunological agents except as described in the *Covered Benefits* section.

- Immunizations related to travel or work.

- Implantable drugs and associated devices, except as described in the *Covered Benefits* section.

- Injectables or infused drugs, except as described in the *Covered Benefits* section.
  - Any charges for the administration of an infused or injected **Prescription Drug** or injectable insulin and other infused or injected drugs covered by **Aetna**;
  - Certain injectable agents such as injectable contrasts/dyes used for imaging (e.g., MRI, CT, Bone Scans), except insulin;
  - Needles and syringes except diabetic needles and syringes, or for a covered drug; and
  - Injectable drugs if an alternative oral drug is available.
  - For 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.

- **Prescription Drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient even if a **Prescription** is written.

- **Prescription drugs** unless the drug is included on the **Preferred Drug Guide (Formulary)** or a medical exception is granted.

- **Prescription** orders filled prior to the effective date or after the termination date of coverage under this **Contract**.

- Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

- Prophylactic drugs for travel.

- Refills over the amount specified by the **Prescription** order. Before recognizing charges, **Aetna** may require a new **Prescription** or proof as to need, if a **Prescription** or refill appears excessive under accepted medical practice standards.

- Refills dispensed more than one year from the date the latest **Prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

- Replacement of lost or stolen **Prescription**s.

- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

- Supplies, devices or equipment of any type, except as specifically provided in the *Covered Benefits* section.

- Test agents except diabetic test agents.

- Tobacco use: 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) unless recommended by the United States Preventive Services Task Force (USPSTF).

TERMINATION OF COVERAGE

A **Member's** coverage under this **Contract** will terminate upon the earliest of any of the conditions listed below and termination will be effective on the date indicated on the *Schedule of Benefits*.

When Coverage Ends For Covered Persons

Your coverage under this **Contract** will end if:

- You no longer meet the eligibility requirements of the state;
- Your premium payment is not received by the end of the grace period;
- You terminate your coverage by notifying **Aetna** in writing 31 days in advance of the termination;
- Discontinuance, under federal or state law, of this product in the state if approved by the Insurance Department of the jurisdiction where this **Contract** was issued;
- **Aetna**'s withdrawal, under federal or state law, from the individual market in the state where this **Contract** was issued if approved by the Insurance Department of the jurisdiction where this **Contract** was issued.

Termination For Cause

Aetna may terminate coverage for cause:

- Upon 31 days advance written notice in the event that **Aetna** does not receive payment from the **Contract Holder** for the entire **Premium** due under this **Contract** within the grace period. Coverage will terminate as of the last day for which **Premiums** were received, subject to the grace period. The termination of this **Contract** following the expiration of the grace period shall not relieve the **Contract Holder** of its obligation to pay the **Premium** for coverage provided during the grace period. Upon 31 days advance written notice, if the **Member** has failed to make any required **Copayment** or any other payment which the **Member** is obligated to pay. Upon the effective date of such termination, prepayments received by **Aetna** on account of such terminated **Member** or **Members** for periods after the effective date of termination shall be refunded to **Contract Holder**.
- Upon 31 days advance written notice, if the **Member** refuses to cooperate and provide any facts necessary for **Aetna** to administer the **Coordination of Benefits** provisions set forth in this **Contract**.
- Immediately, upon discovery of a material misrepresentation by the **Member** in applying for or obtaining coverage or benefits under this **Contract** or upon discovery of the **Member's** commission of fraud against **Aetna**. This may include, but is not limited to, furnishing incorrect or misleading information to **Aetna**, or allowing or assisting a person other than the **Member** named on the identification card to obtain **Aetna** benefits. **Aetna** may, at its discretion, rescind a **Member's** coverage on and after the date that such misrepresentation or fraud occurred. It may also recover from the **Member** the reasonable and recognized charges for **Covered Benefits**, plus **Aetna**'s cost of recovering those charges, including reasonable attorneys' fees. In the absence of fraud or material misrepresentation, all statements made by any **Member** or any person applying for coverage under this **Contract** will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage

or reduction of benefits unless the statement is contained in writing and signed by the **Member**, and a copy of same has been furnished to the **Member** prior to termination.

Coverage will not be terminated on the basis of a **Member's** health status or health care needs, nor if a **Member** has exercised the **Member's** rights under the **Contract's** Complaints and Appeals, **External Review** sections to register a **Complaint** with **Aetna**. The **Complaint** process described in the preceding paragraph applies only to those terminations affected pursuant to the Termination for Cause subsection of the **Contract**.

No termination shall relieve the **Contract Holder** from any obligation incurred prior to the date of termination of this **Contract**.

Aetna shall have no liability or responsibility under this **Contract** for services provided on or after the date of termination of coverage.

Coverage Termination and/or Rescission

Coverage will not be terminated or rescinded on the basis of changes in a covered person's health status or health care needs.

Aetna may terminate or rescind this Contract in the event that a covered person is found to have made an intentional misrepresentation or committed fraud under this Policy.

If you or your covered dependents (or a person seeking coverage on your behalf) commit fraud or make an intentional misrepresentation of fact in obtaining health insurance coverage under this Contract, **Aetna** may rescind your and/or your covered dependent's coverage. This means the Contract will be cancelled back to your Effective Date.

- If we rescind you and/or your covered dependents coverage back to your Effective Date, all premium paid will be refunded to you. You will be responsible for the cost of services, if any, previously received under this Contract. Providers may bill you directly.
- If your coverage under the Contract is rescinded, **Aetna** will provide you with a 30 day advance written notice prior to the date of the rescission.
- If this Contract is rescinded retroactive to its effective date, you have the right to an internal appeal with **Aetna** and/or the right to a third party review conducted by an independent organization.

If you or your covered dependents commit fraud or make an intentional misrepresentation in using medical and/or pharmacy benefits under this Contract, **Aetna** may terminate you and/or your covered dependent's coverage immediately (e.g., using someone's ID card or allowing someone else to use your ID card to obtain medical or pharmacy benefits under this Policy or adding a non-eligible dependent or spouse to this Policy).

If you or your covered dependents commit fraud or make an intentional misrepresentation related to claims or provide information that is fraudulent relating to claims, **Aetna** may terminate you and/or your covered dependent's coverage.

- If we terminate you and/or your covered dependents coverage, you will be responsible for the cost of services previously received under this Contract. Providers may bill you directly.

- If your coverage under the Contract is terminated, **Aetna** will provide you with a written notice mailed to the address as it appears in our records prior to the termination date in accordance with applicable State law.

CONTINUATION

Continuation Coverage for Dependents

If a **Subscriber** dies while covered under this **Contract**, any coverage then in force for the **Covered Dependents** will be continued, provided the **Contract Holder** continues to make **Premium** payments. A **Subscriber's** spouse's coverage will cease when the spouse remarries. Any **Covered Dependent's** coverage, including a spouse's, will cease upon the earliest of:

- A **Covered Dependent** no longer meets the eligibility requirements as outlined in this **Contract**;
- A **Covered Dependent** becomes eligible for similar coverage under this plan or any other plan providing health benefits; or
- Any required contributions cease.

If coverage is being continued for a **Covered Dependent**, a **Subscriber's** child born after the **Subscriber's** death will also be covered.

Handicapped Dependent Children

Coverage for your fully handicapped dependent child may be continued past the limiting age for a dependent child.

Your child is fully handicapped if he or she:

- Is not able to earn his or her own living because of a mental or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- Depends on you for support and maintenance.

Proof that your dependent child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the limiting age under your plan. **Aetna** has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap;
- Failure to give proof that the handicap continues;
- Failure to have any required exam;
- Termination of dependent coverage as to your child for any reason other than reaching the limiting age under your plan.

Continuation Coverage for Dependent Students on Medical Leave of Absence

If a **Member**, who is eligible for coverage and enrolled in **Aetna** by reason of his or her status as a full-time student at a postsecondary educational institution, ceases to be eligible due to:

- A **Medically Necessary** leave of absence from school; or
- A change in his or her status as a full-time student,

resulting from a serious illness or injury, such **Member's** coverage under this **Contract** may continue.

Any **Covered Dependent's** coverage provided under this continuation provision will cease upon the first to occur of the following events:

- The end of the 12 month period following the first day of the dependent child's leave of absence from school, or change in his or her status as a full-time student;
- The dependent child's coverage would otherwise end under the terms of this plan;
- The **Contract Holder** discontinues dependent coverage under this plan; or
- The **Subscriber** fails to make any required premium payments toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence or the change in his or her status as a full-time student.

In order to continue coverage for a dependent child under this provision, the **Subscriber** must notify **Aetna** as soon as possible after the child's leave of absence begins or a change in full time student status occurs. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or other change in full-time student status) is **Medically Necessary**.

If:

- A dependent child's eligibility under a prior plan is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a **Medically Necessary** leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under **Aetna** will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided above.

CLAIMS PROCEDURE, COMPLAINTS AND APPEALS AND EXTERNAL REVIEW

CLAIM PROCEDURES

A claim occurs whenever a **Member** or the **Member's** authorized representative requests precertification as required by the plan from **Aetna**, a **Referral** as required by the plan from a **Participating Provider** or requests payment for services or treatment received. As an **Aetna Member**, most claims do not require forms to be submitted. However, if a **Member** receives a bill for **Covered**

Benefits, the bill must be submitted promptly to **Aetna** for payment. Send the itemized bill for payment with the **Member's** identification number clearly marked to the address shown on the **Member's** ID card.

Aetna will make a decision on the **Member's** claim. Notice of the benefit determination on the claim will be provided to the **Member** within the below timeframes. Under certain circumstances, these time frames may be extended. If **Aetna** makes an **adverse benefit determination**, notice will be provided in writing to the **Member**, or in the case of a concurrent care claim, to the **Participating Provider**. The notice will provide important information about making an **Appeal** of the **adverse benefit determination**. Please see the **Contract** for more information about **Appeals**.

"**Adverse benefit determinations**" are decisions made by **Aetna** that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service or termination of a **Member's** coverage back to the original effective date (rescission). Such adverse benefit determination may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is an **Experimental or Investigational Procedure**.
- A decision that the service or supply is not **Medically Necessary**.

A "**final adverse benefit determination**" is an **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Aetna Timeframe for Notification of a Benefit Determination	
Type of Claim	**Response Time from Receipt of Claim**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible, but not later than 72 hours after the claim is made. If more information is needed to make an **Urgent Care Claim** decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur: • the receipt of the additional information; or • the end of the 48 hour period given the **Physician** to provide **Aetna** with the information.
Pre-Service Claim. A claim for a benefit that requires precertification of the benefit in advance of obtaining medical care.	Within 15 calendar days. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies the **Member** within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Aetna Timeframe for Notification of a Benefit Determination (continued)	
Concurrent Care Claim Extension. A request to extend a course of treatment previously precertified by **Aetna**.	If an urgent care claim as soon as possible, but not later than 24 hours provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **Concurrent Care Claim Extension**.
Concurrent Care Claim Reduction or Termination. Decision to reduce or terminate a course of treatment previously precertified by **Aetna**.	With enough advance notice to allow the **Member** to file an Appeal. If the **Member** files an **Appeal**, **Covered Benefits** under the **Contract** will continue for the previously approved course of treatment until a final **Appeal** decision is rendered. During this continuation period, the **Member** is responsible for any **Copayments** and **Deductibles**, if any, that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **Appeal**. If **Aetna's** initial claim decision is upheld in the final **Appeal** decision, the **Member** will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.
Post-Service Claim. A claim for a benefit that is not a pre-service claim.	Within 30 calendar days. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies the **Member** within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The **Member** will have 45 calendar

	days, from the date of the notice, to provide **Aetna** with the required information.

COMPLAINTS AND APPEALS

Aetna has procedures for **Members** to use if they are dissatisfied with a decision that the **Aetna** has made or with the operation of the **Aetna**. The procedure the **Member** needs to follow will depend on the type of issue or problem the **Member** has.

- **Appeal.** An **Appeal** is a request to the **Aetna** to reconsider an **adverse benefit determination**. The **Appeal** procedure for an **adverse benefit determination** has one level.

- **Complaint.** A **Complaint** is an expression of dissatisfaction about payment or reimbursement for covered benefits; health care services; availability, delivery or quality of care services, including, without limitation, an adverse benefit determination made pursuant to Utilization Review; or the terms and conditions of the **HMO**.

- **External Review.** A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the State of Nevada Office for Consumer Health Assistance and made up of **Physicians** or other appropriate **Providers**. The ERO must have expertise in the problem or question involved.

- **Utilization Review:** The various methods **HMO** may use to review the amount and appropriateness of the provision of a specific health care service to a **Member**. The term does not include an External Review of a **final adverse benefit determination**.

Complaints

If the **Member** is dissatisfied with the administrative services the **Member** receives from the **Aetna** or wants to complain about a **Participating Provider,** call or write Member Services. The **Member** will need to include a detailed description of the matter and include copies of any records or documents that the **Member** thinks are relevant to the matter. The **Aetna** will review the information and provide the **Member** with a written response within 30 calendar days of the receipt of the **Complaint**, unless additional information is needed and it cannot be obtained within this time frame. The response will tell the **Member** what the **Member** needs to do to seek an additional review. If the **Member** calls Member Services about a complaint and the **Member** is not satisfied with the resolution of the complaint, the **Member** must file the complaint in writing to receive further review of the complaint.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide the **Member** with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to the **Member** in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that the **Member** may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, the **Member** must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Appeals of Adverse Benefit Determinations

The **Member** will receive written notice of an **adverse benefit determination** from the **Aetna**. The notice will include the reason for the decision and it will explain what steps must be taken if the **Member** wishes to **Appeal.** The notice will also identify the **Member's** rights to receive additional information that may be relevant to an **Appeal**. Requests for an **Appeal** must be made in writing within 180 calendar days from the date of the notice.

A **Member** may also choose to have another person (an authorized representative) make the **Appeal** on the **Member's** behalf by providing the **Aetna** with written consent. However, in case of an urgent care claim or a pre-service claim, a **Physician** may represent the **Member** in the **Appeal**.

A **Member** may be allowed to provide evidence or testimony during the **Appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

The **Aetna** provides for one level of **Appeal** of the **adverse benefit determination**. A **final adverse benefit determination** notice may provide an option to request an **External Review** *(if available)*. The following chart summarizes some information about how the **Appeals** are handled for different types of claims.

Aetna Timeframe for Responding to an Adverse Benefit Determination Appeal	
Type of Claim	**Level One Appeal** **Aetna Response Time** **from Receipt of Appeal**
Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member,** the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment.	Within 72 hours Review provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

Aetna Timeframe for Responding to an Adverse Benefit Determination Appeal (continued)	
Pre-Service Claim. A claim for a benefit that requires approval of the benefit in advance of obtaining medical care.	Within 15 calendar days Review provided by **Aetna** personnel not involved in making the **adverse benefit determination**.
Concurrent Care Claim Extension. A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a pre-service claim depending on the circumstances.
Post-Service Claim. Any claim for a benefit that is not a pre-service claim.	Within 30 calendar days Review provided by **Aetna** personnel not involved in making the **adverse benefit determination**.

*For assistance with filing a complaint or appealing a decision made by **HMO**, please contact Member Services using the toll-free telephone number shown on your ID card.*

Exhaustion of Process

The foregoing procedures and process are mandatory and must be exhausted prior to:

- Any investigation of a **Complaint** or **Appeal** by the State of Nevada Office for Consumer Health Assistance; or
- The filing of a **Complaint** or **Appeal** with the State of Nevada Office for Consumer Health Assistance; or
- The establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the **Contract** by **Aetna,** or any matter within the scope of the **Complaints** and **Appeals** process.

Under certain circumstances a **Member** may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include Urgent Care Claims and situations where the **Member** is receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **Appeal** requirements of the Federal Department of Health and Human Services, the **Member** is considered to have exhausted the **Appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or an **appeal** straight to an **External Review**. A **Member's** claim or internal **Appeal** *will not* go straight to **External Review** if:

- A rule violation was minor and isn't likely to influence a decision or harm the **Member**;
- It was for a good cause or was beyond **Aetna's** control; and
- It was part of an ongoing, good faith exchange between the **Member** and **Aetna**.

If **HMO** has not issued a written decision within 30 days after the date a **Member** or **Member**'s authorized representative, if any, filed a complaint with **HMO**, and the **Member** or **Member**'s authorized representative have not requested or agreed to a delay, the **Member** or the **Member**'s authorized representative may initiate a request for **External Review** and shall be considered to have exhausted **HMO**'s complaints process.

Record Retention

Aetna shall retain the records of all **Complaints** and **Appeals** for a period of at least 10 years.

Fees and Costs

Nothing herein shall be construed to require **Aetna** to pay counsel fees or any other fees or costs incurred by a **Member** in pursuing a **Complaint** or **Appeal**.

EXTERNAL REVIEW

The **Member** may receive an **adverse benefit determination** or **final adverse benefit determination** notice because **Aetna** determines that:

- The claim involves medical judgment;
- The service or supply is not **Medically Necessary** or appropriate;
- The service or supply is an **Experimental or Investigational Procedure**.

In these situations, **Members** may request an **External Review** if the **Member** or the **Member's Provider** disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- The **Member** received an **adverse benefit determination** notice by **Aetna**, and **Aetna** did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human services.
- The **Member** has received a **final adverse benefit determination** notice of the denial of a claim by **Aetna**.
- The **Member's** claim was denied because **Aetna** determined that the care was not **Medically Necessary** or appropriate or was an **Experimental or Investigational Procedure**.
- The **Member** qualifies for a faster review as explained below.

Aetna's notice of **adverse benefit determination** or **final adverse benefit determination** describes the process to follow if the **Member** wishes to pursue an **External Review** and includes a copy of the *Request for External Review Form*.

You must submit the Request for External Review Form:

- To the State of Nevada Office for Consumer Health Assistance (OCHA)
-
- Within 123 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

For a standard External Review:

- Within 5 business days after receiving the request for **External Review**, OCHA shall notify the **Member**, **HMO**, and other interested parties that a request for **External Review** has been filed.
- As soon as practical, OCHA shall assign the ERO.
- Wtihin 5 business days after receiving the assignment from OCHA identifying the ERO, **HMO** shall provide all documents and materials relating to the **adverse benefit determination** to the ERO.
- Within 5 days after receiving notification from OCHA and the materials from **HMO**, the ERO will review the materials and notify the **Member** if additional information is needed to conduct the review.
- Additional information must be provided to the ERO within 5 days after receiving the request.
- The ERO shall forward a copy of the additional information to **HMO** within 1 business day after receipt.

- Within 15 days of completing the review, the ERO shall submit a copy of its determination to the **Member**.

A faster review is possible if the **Member's Physician** certifies (by telephone or on a separate *Request for External Review Form*) that a delay in receiving the service would:

- Seriously jeopardize the **Member's** life or health; or
- Jeopardize the **Member's** ability to regain maximum function; or
- If the **Adverse Benefit Determination** relates to a **Experimental or Investigational Procedure** treatment, if the **Physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

The **Member** may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued inpatient confinement; or health service for which the **Member** received **Emergency Service**, but has not been discharged from a facility.

For a faster External Review:

- OCHA shall approve or deny a request for faster External Review within 72 hours after it receives proof from the **Member's** provider that the **adverse benefit determination** concerns:
  - an admission;
  - availability of care;
  - continued stay or health care service for emergency care but has not been discharged; or
  - failure to proceed in an expedited manner may jeopardize the **Member**'s life or health.
- Upon determination that the request is eligible for a faster **External Review**, OCHA shall assign an ERO within 1 business day after approving the request.
- **HMO** shall provide all documents and information used to make the **adverse benefit determination** to the ERO within 24 hours after receiving notice from OCHA assigning the request.
- The ERO must complete its review within 48 hours (unless the **Member** and **HMO** agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the ERO must notify the **Member**, the **Member's physician**, and **HMO** of its determination by telephone, followed up in writing within 48 hours.

Faster reviews for **experimental or investigational** treatment can be initiated by oral request to OCHA. When such oral request for expedited **External Review** is made:

- OCHA will immediately notify **HMO** of the request for an expedited **External Review**.
- **HMO** will immediately determine whether the request meets the requirements for review, and shall immediately notify OCHA, the **Member**, and the **Member's** authorized representative, if applicable, of its determination.
- If **HMO** determines that the request for faster **External Review** does not meet the requirements for review, the **Member** or the **Member's** authorized representative, if any, may appeal **HMO**'s determination to OCHA, and regardless of whether the **Member** appeals the determination, OCHA may still determine that the request is eligible for review and require that it be referred for expedited **External Review**. When OCHA makes such determination, the determination

must be made in accordance with the terms of the **Member**'s health benefit plan and is subject to all applicable provisions of the **External Review** process.

- Upon determination that the request for expedited **External Review** meets the requirements for review, OCHA shall immediately assign the ERO, which has been approved by the Commissioner of the State of Nevada Department of Insurance, that will conduct the review of the **Member**'s claim. The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the ERO may consider the **Member**'s medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals and other documents submitted by the **Member**, the **Member**'s authorized representative, if any, the **Member**'s treating provider, and **HMO**, and will follow **HMO's** contractual documents and plan criteria governing the benefits.
- Upon receipt of the notice from OCHA assigning the request, **HMO** shall immediately provide all documents and information used to make the **adverse benefit determination** to the ERO.
- The ERO must complete its review within 48 hours (unless the **Member** and **HMO** agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the ERO must notify the **Member** the **Member**'s **physician**, and **HMO** of its determination by telephone, followed up in writing within 48 hours.

Aetna will abide by the decision of the ERO, except where **Aetna** can show conflict of interest, bias or fraud.

The **Member** is responsible for the cost of compiling and sending the information that they wish to be reviewed by the ERO to the ERO. **Aetna** is responsible for the cost of sending any information to the ERO and for the cost of the **external review**.

For more information about the Complaints and Appeals or **External Review** processes, call the Member Services telephone number shown on the **Member's** ID card.

RECOVERY RIGHTS RELATED TO WORKERS' COMPENSATION

If benefits are provided by **Aetna** for illness or injuries to a **Member** and **Aetna** determines the **Member** received Workers' Compensation benefits for the same incident that resulted in the illness or injuries, **Aetna** will exercise its Recovery Rights against the **Member**.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;
- No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the Member's employment;
- The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the **Member** or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

By accepting benefits under this Plan, the **Member** or the **Member's** representatives agree to notify **Aetna** of any Workers' Compensation claim made, and to reimburse **Aetna** as described above.

RESPONSIBILITY OF MEMBERS

- **Members** or applicants shall complete and submit to **Aetna** such application or other forms or statements as **Aetna** may reasonably request. **Members** represent that all information contained in such applications, forms and statements submitted to **Aetna** incident to enrollment under this **Contract** or the administration herein shall be true, correct, and complete to the best of the **Member's** knowledge and belief.

- The **Member** shall notify **Aetna** immediately of any change of address for the **Member** or any of the **Subscriber's Covered Dependents.**

- The **Member** understands that **Aetna** is acting in reliance upon all information provided to it by the **Member** at time of enrollment and afterwards and represents that information so provided is true and accurate.

- By electing coverage pursuant to this **Contract**, or accepting benefits hereunder, all **Members** who are legally capable of contracting, and the legal representatives of all **Members** who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions in this **Contract**.

- **Members** are subject to and shall abide by the rules and regulations of each **Provider** from which benefits are provided.

GENERAL PROVISIONS

Identification Card

The identification card issued by **Aetna** to **Members** pursuant to this **Contract** is for identification purposes only. Possession of an **Aetna** identification card confers no right to services or benefits under this **Contract**, and misuse of such identification card may be grounds for termination of **Member's** coverage pursuant to the Termination of Coverage section of this **Contract**. If the **Member** who misuses the card is the **Subscriber**, coverage may be terminated for the **Subscriber** as well as any of the **Covered Dependents**. To be eligible for services or benefits under this **Contract**, the holder of the card must be a **Member** on whose behalf all applicable **Premium** charges under this **Contract** have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this **Contract** shall be charged for such services or benefits at billed charges.

If any **Member** permits the use of the **Member's Aetna** identification card by any other person, such card may be retained by **Aetna**, and all rights of such **Member** and their **Covered Dependents**, if any, pursuant to this **Contract** shall be terminated immediately, subject to the Claim Procedures/Complaints and Appeals in this **Contract**.

Reports and Records

Aetna is entitled to receive from any **Provider** of services to **Members**, information reasonably necessary to administer this **Contract** subject to all applicable confidentiality requirements as defined in the General Provisions section of this **Contract**. By accepting coverage under this **Contract**, the **Subscriber**, for himself or herself, and for all **Covered Dependents** covered hereunder, authorizes each and every **Provider** who renders services to a **Member** hereunder to:

- Disclose all facts pertaining to the care, treatment and physical condition of the **Member** to **Aetna**, or a medical, dental, or mental health professional that **Aetna** may engage to assist it in reviewing a treatment or claim;
- Render reports pertaining to the care, treatment and physical condition of the **Member** to **Aetna**, or a medical, dental, or mental health professional that **Aetna** may engage to assist it in reviewing a treatment or claim; and
- Permit copying of the **Member's** records by **Aetna**.

Refusal of Treatment

A **Member** may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a **Participating Provider**. If the **Participating Provider** (after a second **Participating Provider's** opinion, if requested by **Member**) believes that no professionally acceptable alternative exists, and if after being so advised, **Member** still refuses to follow the recommended treatment or procedure, neither the **Participating Provider**, nor **Aetna**, will have further responsibility to provide any of the benefits available under this **Contract** for treatment of such condition or its consequences or related conditions. **Aetna** will provide written notice to **Member** of a decision not to provide further benefits for a particular condition. This decision is subject to the Claim Procedures/Complaints and

Appeals in this **Contract**. Coverage for treatment of the condition involved will be resumed in the event **Member** agrees to follow the recommended treatment or procedure.

Assignment of Benefits

All rights of the **Member** to receive benefits hereunder are personal to the **Member** and may not be assigned.

Legal Action

No action at law or in equity may be maintained against **Aetna** for any expense or bill unless and until the appeal process has been exhausted, and in no event prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in the **Contract**. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

Independent Contractor Relationship

- **Participating Providers**, non-participating **Providers**, institutions, facilities or agencies are neither agents nor employees of **Aetna**. Neither **Aetna** nor any **Member** of **Aetna** is an agent or employee of any **Participating Provider**, non-participating **Provider**, institution, facility or agency.

- Neither the **Contract Holder** nor a **Member** is the agent or representative of **Aetna**, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which **Aetna** has made or hereafter shall make arrangements for services under this **Contract**.

- **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.

- **Aetna** cannot guarantee the continued participation of any **Provider** or facility with **Aetna**. In the event a **PCP** terminates its contract or is terminated by **Aetna**, **Aetna** shall provide notification to **Members** in the following manner:

    - Within 30 days of the termination of a **PCP** contract to each affected **Subscriber**, if the **Subscriber** or any **Dependent** of the **Subscriber** is currently enrolled in the **PCP's** office; and
    - Services rendered by a **PCP** or **Hospital** to an enrollee between the date of termination of the Provider Agreement and 5 business days after notification of the contract termination is mailed to the **Member** at the **Member's** last known address shall continue to be **Covered Benefits**.

- **Restriction on Choice of Providers:** Unless otherwise approved by **Aetna**, **Members** must utilize **Participating Providers** and facilities who have contracted with **Aetna** to provide services.

Inability to Provide Service

If due to circumstances not within the reasonable control of **Aetna**, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or **Hospital** benefits or other services provided under this **Contract** is delayed or rendered impractical, **Aetna** shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid **Premiums** held by **Aetna** on the date such event occurs. **Aetna** is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

Confidentiality

Information contained in the medical records of **Members** and information received from any **Provider** incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for a **Member's** care or treatment, the operation of **Aetna** and administration of this **Contract**, or other activities, as permitted by applicable law. **Members** can obtain a copy of **Aetna's** Notice of Information Practices by calling the Member Services toll-free telephone number listed on the **Member's** identification card.

Limitation on Services

Except in cases of **Emergency Services** or **Urgent Care**, or as otherwise provided under this **Contract**, services are available only from **Participating Providers** and **Aetna** shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a **Member** from any **Physician**, **Hospital**, **Skilled Nursing Facility**, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by **Aetna**.

Incontestability

In the absence of fraud, all statements made by a **Member** shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the **Contract** has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

Effect of Benefits Under Other Plans

Non-Duplication of **Aetna** Benefits

If, while covered under this plan, you are also covered by another **Aetna** individual coverage plan:

- You will be entitled only to the benefits of the plan with the greater benefits, and
- **Aetna** will refund any premium charges received under the plan with the lesser benefits covering the time period both plans were in effect. However, any claims payments made by **Aetna** under the plan with the lesser benefits will be deducted from any such refund of premium.

If while covered under this plan, you are also covered under an **Aetna** group plan:

- You will be entitled only to the benefits of the group plan.
- We will refund any premium received under the individual plan covering the period both plans were in effect. However, any claims payments made by **Aetna** under the individual plan will be deducted from any such refund of premium.

Additional Provisions

The following additional provisions apply to your coverage:

- This **Contract** applies to coverage only, and does not restrict a **Member's** ability to receive health care benefits that are not, or might not be, **Covered Benefits**.

- The **Contract** shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the Nevada Department of Insurance. This can also be done by mutual written agreement between **Aetna** and **Contract Holder** without the consent of **Members**.

- **Aetna** may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this **Contract**.

- No agent or other person, except an authorized representative of **Aetna**, has authority to waive any condition or restriction of this **Contract**, to extend the time for making a payment, or to bind **Aetna** by making any promise or representation or by giving or receiving any information. No change in this **Contract** shall be valid unless evidenced by an endorsement to it signed by an authorized representative of **Aetna**.

  This **Contract**, including the Enrollment Form, Cover Sheet, including the *Schedule of Benefits* and any amendments, endorsements, inserts, or attachments, constitutes the entire **Contract** between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral. There are no warranties, representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this **Contract**. No supplement, modification or waiver of this **Contract** shall be binding unless executed in writing by authorized representatives of the parties.

  All statements made by the **Contract Holder** or a **Member** shall be deemed representations and not warranties. No written statement made by a **Member** shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to the **Member** or his or her beneficiary, or the person making the claim.

  This **Contract** is subject to all rules and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over **Aetna**, and this

Contract shall be deemed to be amended to conform therewith at all times. This **Contract** may be changed at any time for any other reason by agreement between **Aetna** and the **Contract Holder**, without the consent of any **Member** or other person. Except as detailed below, any amendments to this **Contract** shall be in writing and must be approved and executed by authorized representatives of both the **Contract Holder** and **Aetna**. No other individual has the authority to modify this **Contract**; waive any of its provisions, conditions, or restrictions; extend the time for making a payment; or bind **Aetna** by making any other commitment or representation or by giving or receiving any information. No change in this **Contract** shall be valid unless evidenced by an endorsement, signed by an authorized representative of **Aetna**.

Formal acceptance of an amendment to this **Contract** by the **Contract Holder** shall not be required if:

- The change was requested by either the **Contract Holder** or **Aetna** and is agreed to in writing by the other; or
- The change is required to bring the **Contract** into conformance with any applicable federal or state law or regulation, or ruling of the jurisdiction in which the **Contract** is delivered; or
- The **Contract Holder** makes payment of any applicable **Premium** on and after the effective date of such amendment.

- This **Contract** has been entered into and shall be construed according to applicable state and federal law.

Proof of Loss and Claims Payment

*The following provisions apply only as they relate to breast pump services and supplies obtained from a **Non-Participating Provider** and contraceptives obtained from a **pharmacy** under the Preventive Care Benefit. For more information refer to the Preventive Care Benefit earlier in this amendment.*

- **Proof of Loss:** Written proof of loss must be furnished to **Aetna** within 90 days after a **Member** incurs expenses for **Covered Benefits**. Failure to furnish the proof of loss within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give the proof of loss within 90 days, provided the proof of loss is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof of loss may not be furnished later than two years from the date when the proof of loss was originally required. A proof of loss form may be obtained from **Aetna**. If the **Member** does not receive such form before the expiration of 15 days after **Aetna** receives the request, the **Member** shall be deemed to have complied with the requirements of this **Contract** upon submitting within the time fixed in this **Contract** written proof covering the occurrence, character and extent of the loss for which claim is made.
- **Time for Payment of Claim:** Benefits payable under this **Contract** will be paid promptly after the receipt by **Aetna** of satisfactory proof of loss. If any portion of a claim is contested by **Aetna**, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss by **Aetna**.

Change of Residence

It is your responsibility to notify **HMO** within 31 days if you change your residence. If you move outside of the State of Nevada, **HMO** will issue to you a **Contract** with comparable coverage as of the beginning of the **Premium Period** in which the change occurs, without a lapse in coverage suitable to the jurisdiction where you now live, if **Aetna** is authorized to issue the contract in that jurisdiction. The premium for the new coverage will be based upon the premium rates for your new state of residence, and the then ages of the covered dependents. .

If you move within the **HMO Service Area**, premium rates will be adjusted, if necessary, to adjust to your new address and the current ages of your covered dependents, effective at the beginning of the **Premium Period** following the change of residence.

Financial Sanctions Exclusions:

If coverage provided under this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, **Aetna** companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless it is permitted under a written license from the Office of Foreign Asset Control (OFAC). For more information visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Wellness and Other Incentives

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as an Aetna member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation and outcome related thereto in a wellness or health improvement program. Incentives 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; or any combination of thereof. 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.

PREMIUM PAYMENT

The first premium payment for this **Contract** is due on or before your Effective Date. Your subsequent premium payment shall be due on the 1st or the 15th of each month based on your Effective Date. Each premium payment is to be paid to **Aetna** on or before the due date. Your premium becomes overdue following the last day of the **Premium Period**.

A grace period of 31 days will be granted for each premium payment due after the first premium payment. The coverage will remain in force during the grace period.

In the event a premium payment check is returned or dishonored by the bank as non-payable to **Aetna** for any reason, you may be responsible for an additional charge.

Your premium rate will not change for the initial month of this **Contract** provided that there are no changes to this **Contract**, including your area of residence, benefit plan or addition of dependents. However, if there is a change in law or regulation or a judicial decision that has an impact on the cost of providing your covered benefits under this **Contract**, we reserve the right to change your premium rate during this guarantee period.

Your premium rate is based upon factors such as:

- Type and level of benefit plan;
- Your age and the ages of covered dependents;
- The number of covered persons;
- Tobacco use; and
- Place of residence.

Premium rates are expected to change over time as the cost of healthcare services change. We have the right to change premium rates at any time in the future, subject to applicable regulatory review. Each premium will be based on the rates in effect on that premium due date.

In the event of any changes in premium rates, payment of the premium by the **Contract Holder** shall serve as notice of the **Contract Holder's** acceptance of such changes.

We issued this Contract to you in exchange for premium paid by you. **HMO** reserves the right to not accept premium paid by third parties.

We issued this policy to you in exchange for premium paid by you. **Aetna** reserves the right to not accept premium paid by third parties.

DEFINITIONS

The following words and phrases when used in this **Contract** shall have, unless the context clearly indicates otherwise, the meaning given to them below:

Aetna
Aetna Health Inc. is a Pennsylvania corporation that was issued a certificate of authority by the Nevada Department of Insurance and the Department of Health Resources, Health Division to operate as a Health Maintenance Organization.

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

Autism Spectrum Disorder
This means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Biosimilar Prescription Drug(s)
A biological **Prescription Drug** that is highly similar to a U.S. Food and Drug Administration (FDA) licensed reference biological **Prescription Drug** notwithstanding minor differences for which there are no clinically meaningful differences between the highly similar biological **Prescription Drug** and the reference biological **Prescription Drug** in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Body Mass Index
A practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-name Prescription Drug(s)
Prescription drugs and insulin with a proprietary name assigned to it by the manufacturer or distributor and so indicated by MediSpan or any other similar publication designated by **Aetna**.

Calendar Year
This is a twelve-month period starting each January 1 at 12:01 a.m. local time.

Contract
The Individual Advantage **Contract** between **Aetna** and the **Contract Holder**, including the Enrollment Form, including the *Schedule of Benefits*, any riders, and any amendments, endorsements, inserts, or attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority, which outlines coverage for a **Subscriber** and **Covered Dependents**.

Contract Holder
A **Subscriber** who agrees to remit the **Premiums** for coverage under this **Contract** payable to **Aetna**. The **Contract Holder** shall act only as an agent of **Aetna Members** in the **Contract Holder's** family, and shall not be the agent of **Aetna** for any purpose.

Contract Year
A period of 1 year commencing on the **Contract Holder's Effective Date of Coverage** and ending at 12:00 midnight on the last day of the 1 year period.

Copayment
The specified dollar amount or percentage required to be paid by or on behalf of a **Member** in connection with benefits, if any, as set forth in the *Schedule of Benefits*. **Copayments** may be changed by **Aetna** upon 30 days written notice to the **Contract Holder**.

Cosmetic Surgery
Any surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, physical appearance, or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. **Cosmetic Surgery** includes, but is not limited to, ear piercing, rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of **Cosmetic Surgery**.

Covered Dependent
Any person in a **Subscriber's** family who meets all the eligibility requirements of the Eligibility and Enrollment section of this **Contract** has enrolled in **Aetna**, and is subject to **Premium** requirements set forth in the Premiums section of the **Contract**.

Covered Benefits
Those **Medically Necessary Services** and supplies set forth in this **Contract**, which are covered subject to all of the terms and conditions of th**is Contract**.

Custodial Care
Services and supplies that are primarily intended to help a **Member** meet their personal needs. Care can be **Custodial Care** even if it is prescribed by a **Physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. Examples of **Custodial Care** include, but are not limited to:

- Changing dressings and bandages, periodic turning and positioning in bed, administering oral medication, watching or protecting a **Member.**

- 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 stable indwelling bladder catheter, including emptying/changing containers and clamping tubing.
- Adult (or child) day care, or convalescent care.
- Helping a **Member** perform an activity of daily living, such as: walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating, or preparing food.
- Any services that an individual without medical or paramedical training can perform or be trained to perform.

Deductible
The first payments up to a specified dollar amount which a **Member** must make in the applicable calendar year for **Covered Benefits**.

Detoxification
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

Durable Medical Equipment (DME)
Equipment, as determined by **Aetna**, which is:
- made for and mainly used in the treatment of a disease or injury;
- made to withstand prolonged use;
- suited for use while not confined as an inpatient in the **Hospital**;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature; and
- not for exercise or training.

Effective Date of Coverage
The commencement date of coverage under this **Contract** as shown on the records of **Aetna**.

Emergency Service
Professional health services that are provided to treat a **Medical Emergency**.

Experimental or Investigational Procedures
Services or supplies that are, as determined by **Aetna**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) has not been granted for marketing; or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  It is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
- It is provided or performed in special settings for research purposes.

Generic Prescription Drug(s)
Prescription drugs and insulin, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by MediSpan or any other similar publication designated by **Aetna**.

Habilitation
Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Professional(s)
A **Physician** or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual's license or certificate.

Homebound Member
A **Member** who is confined to their place of residence due to an illness or injury which makes leaving the home medically contraindicated or if the act of transport would be a serious risk to their life or health.

Examples where a **Member** would not be considered homebound are:

- A **Member** who does not often travel from home because of feebleness and/or insecurity brought on by advanced age (or otherwise).
- A wheelchair bound **Member** who could safely be transported via wheelchair accessible transport.

Home Health Care Agency
An agency that meets all of the following requirements:

- Mainly provides skilled nursing and other therapeutic services;
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes Contract;

- Has full-time supervision by a **physician** or an **R.N.**;
- Keeps complete medical records on each person;
- Has an administrator; and
- Meets licensing standards.

Home Health Services
Those items and services provided by **Participating Providers** as an alternative to hospitalization, and coordinated and precertified by **Aetna**.

Hospice Care
A program of care that is provided by a **Hospital**, **Skilled Nursing Facility**, hospice, or a duly licensed Hospice Care agency, and is approved by **Aetna**, and is focused on a palliative rather than curative treatment for **Members** who have a medical condition and a prognosis of less than 6 months to live.

Hospital(s)
An institution rendering inpatient and outpatient services, accredited as a **Hospital** by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by **Aetna** as meeting reasonable standards. A **Hospital** may be a general, acute care, rehabilitation or specialty institution.

Infertile or **Infertility**
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Institute of Excellence™ (IOE)
One of a network of facilities specifically contracted with by **Aetna** to provide certain **Transplants** to **Members**. A facility is considered a **Participating Provider** only for those types of **Transplants** for which it has been specifically contracted.

Interested Parties
Means **Contract Holder**, including any and all affiliates, agents, assigns, employees, heirs, personal representatives or subcontractors of an **Interested Party**.

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.
A licensed practical or vocational nurse.

Mail Order Pharmacy
An establishment where **Prescription Drugs** are legally given out by mail or other carrier.

Medical Community
A majority of **Physicians** who are Board Certified in the appropriate specialty.

Medical Emergency
The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Medical Services
The professional services of **Health Professionals,** including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

Medically Necessary, Medically Necessary Services, or Medical Necessity
Health care services that Aetna determines a **physician** or other health care 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 **Aetna** determines are:

- In accordance with generally accepted standards of medical or dental 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**, other health care or dental provider; and
- 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.
- Consistent with the standards set forth in Contract issues involving clinical judgment

Member(s)
A **Subscriber** or **Covered Dependent** as defined in this **Contract**.

Mental Disorders
This is an illness commonly understood to be a **Mental Disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **Behavioral Health Provider** such as a **Psychiatrist**, a psychologist or a psychiatric social worker.

The following conditions are considered a **Mental Disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity
A Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

National Medical Excellence Program
Coordinating **Aetna** services team for **Transplant** services and other specialized care.

Negotiated Charge
As to Health Coverage, (other than Prescription Drug Coverage):
The **Negotiated Charge** is the maximum charge a **Participating Provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Coverage:
The **Negotiated Charge** is the amount **Aetna** has established for each **Prescription Drug** obtained from a **Participating Pharmacy** under this plan. This **Negotiated Charge** may reflect amounts **Aetna** has agreed to pay directly to the **Participating Pharmacy** or to a third party vendor for the **Prescription Drug**, and may include an additional service or risk charge set by **Aetna**.

The **Negotiated Charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **Prescription Drug**, including **Prescription Drugs** on the **Preferred Drug Guide (Formulary)**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **Prescription Drugs** and 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
Is a retail **Pharmacy**, mail order **Pharmacy** or **Specialty Network Pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, to furnish services and supplies for this plan. The appropriate **Pharmacy** type may also be substituted for the word **Pharmacy**. (E.g. retail **Network Pharmacy,** mail order **Network Pharmacy** or **Specialty Network Pharmacy**).

Non-Hospital Facility
A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons, except for transitional living facilities.

Non-Participating Providers
These are **Providers** that are not **Participating Providers**.

Non-Preferred Drug (Non-Formulary)
is a **Prescription Drug** or device that is not listed in the **Preferred Drug Guide (Formulary)**. This includes **Prescription Drugs** and devices on the **Preferred Drug Guide Exclusions List** that are approved by medical exception.

Partial Hospitalization
The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis and which is designed for a patient or client who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. The program must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis;
- It is in line with accepted medical practice for the condition of the person;
- It does not require full-time confinement;
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect

Participating
A description of a **Provider** that has entered into a contractual agreement with **Aetna** for the provision of services to **Members**.

Participating Infertility Specialist
A **Specialist** who has entered into a contractual agreement with **Aetna** for the provision of **Infertility** services to **Members**.

Physician(s)
- Has an M.D., D.O., or D.P.M. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate including a chiropractor, a clinical professional counselor, a marriage and family therapist, a registered nurse (R.N.), a psychologist, an associate in social work, a social worker, an independent social worker and a clinical social worker, and for the practice of acupuncture and herbal medicine a person who is licensed to practice oriental medicine. ("Oriental medicine" means that system of the healing art which places the chief emphasis on the flow and balance of energy in the body mechanism as being the most important single factor in maintaining the well-being of the organism in health and disease.).

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**;
- A **physician** is not you or related to you.

Premium Period
The **Premium Period** is the span of time which begins at either the 1st or 15th of the month based on your Effective Date and ends 30 days later.

Preferred Drug (Formulary)
A **Prescription Drug** or device that is listed on the **Preferred Drug Guide (Formulary)**.

Preferred Drug Guide (Formulary)
A listing of **Prescription Drugs** established by **Aetna** or an affiliate, which does not cover all **Prescription Drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **Preferred Drug Guide (Formulary)** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **Prescription Drugs** in the **Preferred Drug Guide (Formulary)** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna** or an affiliate.

Preferred Network Pharmacy
A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Premium Period
The **premium period** is the span of time which begins at either the 1st or 15th of the month based on your Effective Date and ends 30 days later.

Prescription
*As to **Prescription Drugs**:*
A written order for the dispensing of a **Prescription Drug** by a **Provider**. If it is a verbal order, it must promptly be put in writing by the **Pharmacy**.

As to vision care:
A written order for the dispensing of **Prescription** lenses or **Prescription** contact lenses by an ophthalmologist or optometrist.

Prescription Drug

A drug, biological, or compounded **Prescription** which, by State and Federal Law, may be dispensed only by **Prescription.** This includes:

> An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional.

Prescription Drug Deductible Amount
The specified amount of **Covered Benefits** for **Prescription Drug**s which a **Member** or a family unit (as the case may be) is required to pay before **Aetna** pays any benefits, if applicable under the plan. **Covered Benefits** which are used in satisfying the **Prescription Drug Deductible Amount** must be incurred and applied to such **Prescription Drug Deductible Amount** within the applicable **Calendar Year**; **.** This amount will not reflect or include any amount **Aetna**, an affiliate or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor, and a drug manufacturer for any drugs, including any drugs on the **Drug Formulary**.

Primary Care Physician (PCP)
A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

Provider(s)
A **Physician**, **Health Professional**, **Hospital**, **Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **Substance Abuse** or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **Hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **Psychiatrist** who is responsible for patient care and is there regularly.
- Is staffed by **Psychiatrists** involved in care and treatment.
- Has a **Psychiatrist** present during the whole treatment day.
- Provides, at all times, **Psychiatric** social work and nursing services.
- Provides, at all times, **Skilled Nursing Services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **Psychiatrist**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.

Psychiatrist
This is a **Physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of **Substance Abuse** or **Mental Disorders**.

Referral
Specific directions or instructions from a **Member's PCP,** in conformance with **Aetna's** policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.

Residential Treatment Facility (**Mental Disorders**)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA), or is credentialed by **Aetna.**
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- 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**.

Residential Treatment Facility (**Substance Abuse**)
This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF),American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a **behavioral health provider** or an appropriately state certified professional (for example, CADC; CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **Physician** who is an addiction **Specialist**.

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An **R.N.** is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

Respite Care
Care furnished during a period of time when the **Member's** family or usual caretaker cannot, or will not, attend to the **Member's** needs.

Retail Pharmacy
A community **pharmacy** which has contracted with **Aetna**, an affiliate, or a third party vendor, to provide covered outpatient **Prescription Drugs** to you.

Self-injectable Drug(s)
Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions.

Service Area
The geographic area established by **Aetna** and approved by the appropriate regulatory authority.

Skilled Care

Medical care that requires the skills of technical or professional personnel.

Skilled Nursing
Services that require the medical training of and are provided by a licensed nursing professional and are not **Custodial Care**.

Skilled Nursing Facility
An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing **Skilled Nursing** care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. **Skilled Nursing Facility** does not include institutions which provide only minimal care, **Custodial Care** services, ambulatory or part-time care services, or institutions which primarily provide for the care and treatment of **Mental Disorder** and **Substance Abuse**. The facility must qualify as a **Skilled Nursing Facility** under Medicare or as an institution accredited by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, the Commission on the Accreditation of Rehabilitative Facilities, or as otherwise determined by the health insurer to meet the reasonable standards applied by any of the aforesaid authorities. Examples of **Skilled Nursing Facilities** include Rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a **Hospital** designated for Skilled or Rehabilitation services.

Specialist(s)
A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

Specialty Care
Health care services or supplies that require the services of a **Specialist**.

Specialty Care Prescription Drugs
Injectable, infusion and oral prescription drugs that are prescribed to address complex, chronic diseases with associated co-morbidities such as: cancer, rheumatoid arthritis, hemophilia, multiple sclerosis. You can access the list of these **Specialty Care Prescription Drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.Aetna.com.

Specialty Network Pharmacy
A network of pharmacies designated to fill **Prescriptions** for **Self-injectable Drugs and Specialty Care Prescription Drugs**.

Step Therapy Program
A form of **precertification** under which certain **Prescription Drug**s will be excluded from coverage**,** unless a first-line therapy drug(s) is used first by the **Member**. The list of **Step Therapy** drugs is subject to change by **Aetna**. An updated copy of the list of drugs subject to step therapy shall be available upon request by the **Member** or may be accessed at the **Aetna** website, at www.aetna.com.

Subscriber
A person who meets all applicable eligibility requirements as described in this **Contract** has enrolled in **Aetna**, and is subject to **Premium** requirements as set forth in the *Premiums* section of the **Contract**.

Substance Abuse
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation
Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

Surgery or Surgical Procedure
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Therapeutic Drug Class
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

Tier 1A
A group of medications determined by **Aetna** that may be available at a reduced **copayment/coinsurance** and are noted in the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.Aetna.com/formulary.

Tier 1
A group of medications determined by **Aetna** that may be available at a reduced **copayment/coinsurance** and are noted on the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.Aetna.com/formulary.

Totally Disabled or Total Disability
A **Member** shall be considered **Totally Disabled** if:

- The **Member** is a **Subscriber** and is prevented, because of injury or disease, from performing any occupation for which the **Member** is reasonably fitted by training, experience, and accomplishments; or
- The **Member** is a **Covered Dependent** and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Transplant
Replacement of solid organs; stem cells; bone marrow or tissue.

Transplant Occurrence
Considered to begin at the point of authorization for evaluation for a **Transplant**, and end on the later of:

- 365 days from the date of the **Transplant**; or
- upon the date the **Member** is discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the **Transplant**.

Urgent Care
Non-preventive or non-routine health care services which are **Covered Benefits** and are required in order to prevent serious deterioration of a **Member's** health following an unforeseen illness, injury or condition if: (a) the **Member** is temporarily absent from the **Aetna Service Area** and receipt of the health care service cannot be delayed until the **Member** returns to the **Aetna Service Area**; or, (b) the **Member** is within the **Aetna Service Area** and receipt of the health care services cannot be delayed until the **Member's Primary Care Physician** is reasonably available.

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

Contact Us:

Throughout this Contract, there are statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your benefits, please contact us. We look forward to assisting you.

Online

Visit our website

www.aetna.com

Aetna Navigator

www.aetnanavigator.com

DocFind®
www.docfind.com

Aetna Specialty Rx
www.aetnaspecialtycarerx.com

Telephone

Please contact **Aetna** at the toll-free number on the back of your ID card.

Mail

Aetna
Attn: Enrollment
P.O. Box 730
Blue Bell, PA 19422

PCP and PCP referred coverage (in-network) under the Health Maintenance Organization (HMO) plan

Schedule of Benefits

Underwritten by Aetna Health Inc in the state of Nevada

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Schedule of Benefits

This Schedule of Benefits lists the **Deductibles** and **Copayments** or **Coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with **Deductibles** and **Copayments** or **Coinsurance** and any limits that apply to the services.

How to read the Schedule of Benefits

- You are responsible to pay any **Deductibles** and **Copayments** or **Coinsurance**.
- You are responsible for full payment of any health care services received that are not a **Covered Benefit**.
- This plan has limits for specific **Covered Benefits**. For example, these could be visit, day or dollar limits. They may be combined limits between or separate limits for **Participating Providers** and **Non-Participating Providers** unless we state otherwise.

Important note:
All **Covered Benefits** are subject to the **Deductible** and **Copayment** or **Coinsurance** unless otherwise noted in the Schedule of Benefits below.

For answers to any questions, contact Member Services by logging onto the Aetna Navigator® secure website at www.aetna.com or at the toll-free number on your Membership ID card.

The coverage described in this Schedule of Benefits will be provided under the **Aetna Health Inc** Policy**.** This Schedule of Benefits replaces any Schedule of Benefits previously in effect under the Policy. Keep this Schedule of Benefits with your Policy

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Plan features	Cost share/Deductible/Limits
	In-network coverage*
Deductible	
You have to meet the **Deductible** before this plan pays for benefits.	
Individual	$6,850 per **Calendar Year**
Family	$13,700 per **Calendar Year**

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Maximum Out-of-Pocket Limit	
Maximum Out-of-Pocket Limit per **Calendar Year**	
Individual	$6,850 per **Calendar Year**
Family	$13,700 per **Calendar Year**

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum Out-of-Pocket Limits**
- Limits

that are listed in this Schedule of Benefits.

Deductible Provisions
Covered Benefits that are subject to the **Deductible** include **Prescription Drug Covered Benefits** provided under the medical plan and the **Outpatient Prescription Drug** plan
The **Deductible** may not apply to certain **Covered Benefits**. You must pay any applicable **Copayments** or **Coinsurance** for **Covered Benefits** to which the **Deductible** does not apply.
Individual This is the amount you owe for **Covered Benefits** each **Calendar Year** before the plan begins to pay for **Covered Benefits**. This **Calendar Year Deductible** applies separately to you and each **Covered Dependent**. After the amount you pay for **Covered Benefits** reaches the **Calendar Year Deductible**, this plan will begin to pay for **Covered Benefits** for the rest of the **Calendar Year**.
Family This is the amount you owe for **Covered Benefits** each **Calendar Year** before the plan begins to pay the **Covered Benefits**. After the amount you pay for **Covered Benefits** reaches this family **Calendar Year Deductible**, this plan will begin to pay for **Covered Benefits** that the 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 **Covered Benefits** that you and each **Covered Dependent** 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 you must pay at the time **Covered Benefits** are received from a **Participating Provider**.
Per admission **Copayment,** if any A per admission **Copayment** is an amount required to be paid when you have a stay as an inpatient in an inpatient facility. These **Copayments** are in addition to any other **Copayments** applicable under this plan.
Coinsurance
The specific percentage you have to pay for a health care service listed in the Schedule of Benefits.
Separate **Coinsurance** and **Deductibles** may apply per facility. These **Coinsurance** and **Deductibles** are in addition to any other **Coinsurance** and **Deductibles** applicable under this plan. They may apply to each inpatient stay or they may apply on a per day basis up to a per admission limit amount. If you are in the same type of facility more than once, and the inpatient stay is separated by less than 48 hours (regardless of cause), only one per admission **Coinsurance** and **Deductibles** will apply. Not more than

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

three per admission **Coinsurance** and **Deductibles** will apply for each facility type during a **Calendar Year**

Maximum Out-of-Pocket Limits Provisions

Covered Benefits that are subject to the **Maximum Out-of-Pocket Limit** include **Prescription Drug Covered Benefits** provided under the medical plan and the **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 **Covered Benefits** 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 covered person must meet their **Maximum Out-of-Pocket Limit** separately.

Individual

Once the amount of the **Copayments, Coinsurance** and **Deductibles** you or your **Covered Dependents** have paid for **Covered Benefits** during the **Calendar Year** meets the individual **Maximum Out-of-Pocket Limit**, this plan will pay 100% of the **Covered Benefits** that apply toward the limit for the rest of the **Calendar Year** for that person.

Family

Once the amount of the **Copayments** or **Coinsurance** and **Deductibles** you or your **Covered Dependents** have paid for **Covered Benefits** during the **Calendar Year** meets this family **Maximum Out-of-Pocket Limit**, this plan will pay 100% of the **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 covered persons. The family **Maximum Out-of-Pocket Limit** can be met by a combination of covered persons with no single person contributing more than the individual **Maximum Out-of-Pocket Limit** amount in a **Calendar Year**.

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **Copayment** or **Coinsurance** for **Covered Benefits** during the **Calendar Year**. This plan has an individual and family **Maximum Out-of-Pocket Limit**.

Certain costs that you incur do not apply toward the **Maximum Out-of-Pocket Limit**. These include:

- All costs for non-covered services
- Certain other **Covered Benefits** in the Schedule of Benefits

Covered Benefits	In-network coverage*
1. Preventive care and wellness • **Routine physical exams-** Performed at a **Physician, PCP** office • **Preventive care immunizations-** Performed in a facility or at a **Physician** office • **Well woman preventive visits--** routine gynecological exams (including pap smears)- Performed at a **Physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office • **Screening and counseling services -** Includes 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 - Office visits • **Tobacco cessation and over-the-counter drugs** • **Routine cancer screenings** - (applies whether performed at a **Physician**, **PCP**, **Specialist** office or facility) • **Prenatal Care -** (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN) • **Comprehensive lactation support and counseling services -** Facility or office visits • **Family planning services – Female Contraceptives including voluntary sterilization**	
	0% per visit
Preventive care and wellness benefit limitations	
Routine physical exams	
Limitations	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 the **Physician.**
Preventive care immunizations	
Limitations	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 the **Physician.**
Well woman preventive visits **Routine gynecological exams (including pap smears)**	
Limitations	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Screening and counseling services: limitations are per **Calendar Year** unless stated	
Obesity and/or healthy diet	Coverage is limited to: age 0-22, unlimited visits; age 22+, 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling.

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Misuse of alcohol and/or drugs	Coverage is limited to 5 visits every 12 months
Use of tobacco products	Coverage is limited to 8 visits every 12 months.
Sexually transmitted infection	Coverage is limited to 2 visits every 12 months.
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

Tobacco Cessation Prescription and Over-the-Counter Drugs

For each 30 day supply filled at a **Retail Pharmacy**	0% per **prescription** or refill

Maximums:

- Coverage is permitted for two, 90-day treatment regimens only. Any additional treatment regimens will be paid according to the tier of drug per the schedule of benefits, above.
- Coverage only includes generic drug when a brand-name drug is available.

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 the Aetna Navigator® secure website at www.aetna.com or calling the number on the back of your Membership ID card.

Routine cancer screenings

Limitations:	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. • Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.

Comprehensive lactation support and counseling services

Lactation counseling services maximum visits per **Calendar Year** either in a group or individual setting Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	Coverage is limited to 6 visits

Breast feeding durable medical equipment

Important note:
You should review the *Maternity and related newborn care* section. This will give more information on coverage levels for maternity care under this plan. See the *Breast feeding durable medical equipment* section of the plan for limitations on breast pump and supplies.

Family planning services – female contraceptives

Contraceptive counseling services maximum visits per **Calendar Year** either in a group or individual setting	Coverage is limited to 2 visits

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	In-network coverage*
2. Physicians and other Health Professionals	
Primary Care Physician Benefit	
Office hours visits (non-surgical) non preventive care	$15 **copay,** no **deductible** applies
Allergy injections	
Without **Physician, PCP** or **Specialist** office	0% after **deductible**
Allergy testing and treatment	
Performed at a **Physician, PCP** or **Specialist** office	Covered same as **PCP/Specialist**
Immunizations when not part of the physical exam	
Immunizations when not part of the physical exam	0%, no **deductible** applies
Injectable medications	
Performed at a **Physician, PCP** or **Specialist** office	Covered same as **PCP/Specialist**
Physician surgical services	
Performed at a **Physician** or **Specialist** office	Covered same as **PCP/Specialist**
Alternatives to Physician office visits	
Walk-in clinic visits	
Walk-In Clinic non-emergency visit (includes coverage for immunizations.)	Not covered
Teledoc Telemedicine consultations	
E-visit online consultation by **a Physician, PCP**	$15 **copay,** no **deductible** applies
Teledoc Telemedicine consultation by **a Physician, PCP**	$15 **copay,** no **deductible** applies
E-visit online consultation by **a Specialist**	0% after **deductible**
Teledoc Telemedicine consultation by **a Specialist**	$15 **copay,** no **deductible** applies
Specialist office visits	
Office hours visit (non-surgical)	0% after **deductible**

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	In-network coverage*
3. Hospital and other facility care	
Hospital care	
Inpatient **Hospital**	0% after **deductible**
Skilled nursing facility	
Inpatient facility	0% after **deductible**
Day limit per **Calendar Year**	Coverage is limited to 100 days per **calendar year.**
Outpatient surgery	
Performed in **Hospital** outpatient department	0% after **deductible**
Performed in facility other than **Hospital** outpatient department	0% after **deductible**
Home health care	
Outpatient	0% after **deductible**
Visit limits per **Calendar Year**	Coverage is limited to 30 visits per **calendar year.**
Hospice	
Inpatient facility and other **Hospice** benefits during a **stay**	0% after **deductible**
Hospice	
Outpatient	0% after **deductible**

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	In-network coverage*
4. Emergency Care and Urgent Care A separate **Hospital** emergency room or Urgent Care **Deductible** or **Copayment** will apply for each visit to an emergency room or an **Urgent Care Facility**.	
Hospital emergency room	0% after **deductible**
Non-emergency care in a **Hospital** emergency room	Not covered
Important note: • Please note that as **Non-Participating Providers** are not Participating Providers and do not have a contract with **Aetna,** 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 hospital emergency room facility or **provider** bills **you** for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill to the address listed on the back of your **Membership** ID card, and **Aetna** will resolve any payment dispute with the **Provider** over that amount. Make sure your **Membership** ID number is on the bill. • A separate hospital emergency room copayment or coinsurance will apply for each visit to an emergency room. If you are admitted to a **Hospital** as an inpatient right after a visit to an emergency room, your emergency room **Copayment** will be waived and the inpatient **Copayment** will apply. • A separate urgent care copayment or coinsurance will apply for each visit to an urgent care provider. Covered benefits that are applied to the urgent care copayment or coinsurance cannot be applied to any other copayment or coinsurance under this plan. And, covered benefits that are applied to your plan's other copayments, deductibles or coinsurance cannot be applied to the urgent care copayment or coinsurance. **Covered benefits that are applied to the emergency room copayment or coinsurance cannot be applied to any other Deductible or coinsurance under this plan. And, covered benefits that are applied to any of your plan's other Deductibles, copayments or coinsurance cannot be applied to the emergency room copayment or coinsurance.**	
Urgent medical care at a non-**Hospital** free standing facility	$100 **copay,** no **deductible** applies
Non-urgent use of **Urgent Care Facility** at a non-**Hospital** free standing facility	Not covered

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	In-network coverage*
5. Specific conditions	
Maternity and related newborn care	
Inpatient and other maternity and related newborn care services and supplies	0% after **deductible**
For in-network services, any **Copayment** that is collected applies to the delivery and postpartum care services provided by an OB's, GYN's, or OB/GYN's only. No **Copayment** that is collected applies to prenatal care services provided by an OB's, GYN's, or OB/GYN's. See the *Prenatal care* sections for cost-sharing and limits that apply to these services.	
Delivery services and postpartum care services	
Performed in a facility or at a **Physician** office	Covered according to the type of service provided and the place where the service is received.
Other prenatal care services	0%, no **deductible** applies
Reconstructive breast surgery	
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received.
Reconstructive or cosmetic services and supplies	
Reconstructive surgery and supplies	Covered according to the type of benefit and the place where the service is received.
Mental Disorders Coverage is provided under the same terms, conditions as any other illness.	
Inpatient facility and other inpatient services and supplies	0% after **deductible**
Residential treatment Coverage is provided under the same terms, conditions as any other illness.	
Inpatient facility and other inpatient services and supplies	0% after **deductible**
Mental Disorders Coverage is provided under the same terms, conditions as any other illness.	
Outpatient visits to a **Physician** or **Behavioral Health Provider**	0% after **deductible**
Partial Hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	
Substance Abuse	
Detoxification Coverage is provided under the same terms, conditions as any other illness.	
Outpatient	0% after **deductible**
Partial Hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	
Rehabilitation Coverage is provided under the same terms, conditions as any other illness.	

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Inpatient and other inpatient services and supplies	0% after **deductible**
Residential treatment Coverage is provided under the same terms, conditions as any other illness.	
Inpatient facility and other inpatient services and supplies	0% after **deductible**
Rehabilitation Coverage is provided under the same terms, conditions as any other illness.	
Outpatient	0% after **deductible**
Partial Hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for treatment of **Substance Abuse** provided under the direction of a **Physician**. **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program for treatment of **Substance Abuse** provided under the direction of a **Physician.**	
Autism spectrum disorders	
Autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.
Diabetes	
Diabetic equipment	Covered according to the type of benefit and the place where the service is received
Diabetic supplies	Covered according to the type of benefit and the place where the service is received
Diabetic education	Covered according to the type of benefit and the place where the service is received
Treatment of basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received
Comprehensive Infertility	
Comprehensive **infertility** expenses for: • Artificial Insemination • Ovulation Induction	Covered according to the type of benefit and the place where the service is received.
Artificial Insemination benefit limit. Maximum benefit per Lifetime	6 courses of treatment
Ovulation Induction benefit limit. Maximum benefit per Lifetime	6 courses of treatment

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	Network (IOE facility)	Network (Non-IOE facility
Transplant services facility and non-facility Coverage at the in-network cost share is limited to **IOE** only.		
Inpatient and other inpatient services and supplies Coverage at the in-network cost share is limited to IOE only. Non-IOE par facilities and out-of-network facilities are covered at out-of-network cost sharing.	0% after **deductible**	No benefit is provided.
Outpatient	Covered according to the type of benefit and the place where the service is received	No benefit is provided.
Physician services	0% after **deductible**	No benefit is provided.
Transplant Travel and Lodging Expenses		
Maximum Benefit payable for **IOE** Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	Not covered
Maximum Benefit payable for Lodging Expenses per IOE patient	$200 per day	Not covered

Covered Benefits	In-network coverage*
6. Specific therapies and tests	
Diagnostic and preoperative testing	
Diagnostic complex imaging services	
Complex imaging services	0% after **deductible**
Outpatient diagnostic lab work	
Lab work	0% after **deductible**
Outpatient diagnostic radiological services	
X-ray	0% after **deductible**
Outpatient preoperative testing	
Performed in the outpatient department of a **Hospital**	0% after **deductible**
Performed at an outpatient facility other than outpatient department of a **Hospital**	0% after **deductible**
Clinical trial therapies (Experimental or Investigational Procedures)	
Clinical trial therapies (including routine patient costs)	Covered according to the type of benefit and the place where the service is received.
Outpatient therapies	
Infusion therapy	
Performed in a **Physician** office or in a person's home	0% after **deductible**
Performed at outpatient facility	0% after **deductible**
Chemotherapy	
Chemotherapy	Covered according to the type of benefit and the place where the service is received.
Radiation therapy	
Radiation therapy	Covered according to the type of benefit and the place where the service is received.
Specialty Care Prescription Drugs	
• Performed in a **Physician** office or in the home • Performed at outpatient facility	Covered according to the type of benefit and the place where the service is received.
Short-term cardiac and pulmonary rehabilitation services	
Cardiac and pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received.
Visit limit* per **Calendar Year**	Coverage is limited to 60 visits per **calendar year** PT/OT/ST combined, rehabilitation & habilitation separate.
***A visit is equal to no more than 1 hour of therapy.	
Short-Term Rehabilitation Therapy Services	
Outpatient Cognitive Therapy, Physical Therapy Occupational Therapy and Speech Therapy Rehabilitation Benefits	
Physical, occupational, speech and cognitive rehabilitation therapies	0% after **deductible**

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Visit limit* per **Calendar Year**	Coverage is limited to 60 visits per **calendar year** PT/OT/ST combined, rehabilitation & habilitation separate.
***A visit is equal to no more than 1 hour of therapy.	
Habilitation Therapy Services	
All therapies	0% after **deductible**
Visit limit* per **Calendar Year**	Coverage is limited to 60 visits per year
***A visit is equal to no more than 1 hour of therapy.	
Applied behavior analysis	
Applied behavior analysis	0% after **deductible**
***A visit is equal to no more than 1 hour of therapy.	
Spinal manipulation	
Spinal manipulation	0% after **deductible**
Visit limit per **Calendar Year**	Coverage is limited to 12 visits per **calendar year.**

Covered Benefits	In-network coverage*
7. Other Covered Benefits	
Ambulance service	
Ground **Ambulance**	0% after **deductible**
Air or water **Ambulance**	0% after **deductible**
Non-emergency ambulance	0% after **deductible**
Anesthesia and hospital charges for dental care	
	Covered according to the type of benefit and the place where the service is received.
Durable Medical Equipment (DME)	
DME	0% after **deductible**
Hormone replacement therapy	
	Covered according to the type of benefit and the place where the service is received.
Family planning services- other	
• Voluntary sterilization for males	0% after **deductible**
• Voluntary Termination of Pregnancy	Not Covered
Outpatient services	
• Voluntary sterilization for males	Covered according to the type of benefit and the place where the service is received
Voluntary Termination of Pregnancy	Not Covered
Hearing aid benefit	
	0% after **deductible**
Maximum benefit	1 hearing aid per ear per every 48 months
Clinical trial therapies (Experimental or Investigational Procedures)	
Clinical trial therapies (including routine patient costs)	Covered according to the type of benefit and the place where the service is received.
Jaw Joint Disorder	
Jaw Joint Disorder treatment	Covered according to the type of benefit and the place where the service is received.
Bariatric Surgery	
Bariatric **Surgery**	0% after **deductible**
Maximum benefit	Coverage is limited to 1 procedure per lifetime.
Nutritional supplements	
Nutritional supplements	0% after **deductible**
Prosthetic devices	
Prosthetic devices	0% after **deductible**
Vision Care Benefits	
Pediatric vision care **Coverage is limited to covered persons through the end of the month in which the person turns 19**	

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Routine vision exams (including refraction)	
Performed by an ophthalmologist or optometrist	$0 **copay**
Visit limit per **Calendar Year**	Coverage is limited to 1 exam per **calendar year.**
Low vision services	No less than 1 exam every five years
Vision care services and supplies	
Office visit for fitting of contact lenses	Not covered
Preferred or non-preferred eyeglass frames, **Prescription** lenses or **Prescription** contact lenses.	$0 **copay**
Number of eyeglass frames per **Calendar Year**	One set of eyeglass frames
Number of **Prescription** lenses per **Calendar Year**	One pair of **Prescription** lenses
Number of **Prescription** contact lenses per **Calendar Year** (includes non-conventional **Prescription** contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable Lenses: one set
Adult vision care **Limited to covered persons age 19 and over**	
Vision care services and supplies	
includes non-conventional **Prescription** contact lenses and aphakic lenses prescribed after cataract surgery	Non-disposable Lenses: one set
*__Important note:__ Refer to the *Vision Care Benefits* section in the plan for the explanation of these vision care supplies. As to coverage for **Prescription** lenses in a **Calendar Year**, this benefit will cover either **Prescription** lenses for eyeglass frames or **Prescription** contact lenses, but not both. Exception: when an aphakic lens is prescribed after cataract surgery, we will cover eyeglass frames in addition to the lens. Coverage does not include the office visit for the fitting of **Prescription** contact lenses	

Pediatric dental

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

Type A services • Preventive care • Diagnostic care	 0% no deductible applies 0%, no **deductible** applies
Type B services	0% after **deductible**
Type C services	0% after **deductible**
Orthodontic services	0% after **deductible**
Dental emergency limit:	$75

The dental emergency limit is the most the plan will pay for health care services incurred by you for any one dental emergency.

Dental benefits are subject to the medical plan's **Deductibles** and M**aximum Out-of-Pocket Limits** as explained on the Schedule of Benefits.

Type A Services: Diagnostic and Preventive Care

Visits and images

- Office visit during regular office hours, for oral examination (limited to: 2 visits every 12 months)
- Routine comprehensive or recall examination (limited to: 2 visits every 12 months)
- Problem-focused examination
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride, (limited to: 2 courses per year)
- Topical fluoride varnish (limited to: 2 courses per year)
- Sealants (limited to: one application per tooth every 3 years for permanent molars)
- Preventive resin restoration (limited to one application every 3 years for permanent molars only)
- Oral hygiene instructions (limited to 2 treatments per year)
- Bitewing images (limited to: 2 sets per year)
- Complete image series, including bitewings (limited to: 1 set every 11 months)
- Panoramic film (limited to 1 set every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images

Space maintainers

- Only when needed to preserve space resulting from premature loss of primary teeth. (includes all adjustments within 6 months after installation.)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Re-cementation of space maintainer
- Removal of space maintainer

Type B Services: Basic Restorative Care

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit
- Office visit for observation

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

- Consultation by other than the treating provider (limited to 1 per year)
- Hospital or ambulatory surgery center call (when medically necessary)
- House call/extended care facility call (when medically necessary)

Images and pathology

- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and accession of tissue examination of oral tissue
- Therapeutic drug injection
- Therapeutic parental drugs

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted teeth
  - Removal of tooth (soft tissue)
- Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Surgical removal of residual tooth roots
- Other surgical procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Removal of torus mandibularis
  - Transplantation of tooth or tooth bud
  - Tooth reimplantation
  - Closure of oral fistula of maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Frenuloplasty
  - Excision of pericoronal gingiva
  - Suture of soft tissue injury
  - Biopsy of oral tissue (hard and soft tissue)
  - Collection of microorganisms for culture and sensitivity

Periodontics

- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to 4 separate quadrants every 12 months)

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

- Root planing and scaling – 1 to 3 teeth per quadrant (limited to 4 separate quadrants every 12 months)
- Gingivectomy, per quadrant (limited to 1 for each quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant (limited to 1 for each site every 3 years)
- Additional crown exposure, per quadrant
- Gingival flap procedure - per quadrant
- Gingival flap procedure – 1 to 3 teeth per quadrant
- Periodontal maintenance procedures following active therapy (limited to: 4 per year)
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Pulpal regeneration
- Apexification/recalcification
- Apicoectomy
- Retrograde filing
- Root amputation
- Endodontic endosseous implant
- Hemisection (including any root removal)
- Root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid
- Retreatment of root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid

Restorative dentistry Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)

- Amalgam restorations
- Protective restorations
- Occlusal adjustments
- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Re-cementation
  - Inlay
  - Crown
  - Bridge
  - Fixed partial denture
  - Cast or prefabricated post

Type C Services: Major Restorative Care

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Oral Surgery

- Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)
  - Removal of impacted tooth with surgical complications
- Soft tissue graft procedures
- Clinical crown lengthening

Periodontics

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 for each site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 for each quadrant every 3 years)
- Bone replacement graft, per quadrant/additional sites
- Biologic materials
- Guided tissue regeneration
- Soft tissue graft procedures
- Pedical soft graft procedure
- Subepithelia connective tissue graft, by tooth
- Full mouth debridement
- Distal or proximal wedge procedure
- Provisional splinting, intracoronal/extracoronal

Endodontics

- Molar root canal therapy including **medically necessary** images
- Retreatment of molar root canal therapy including **medically necessary** images

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to: 1 per tooth every 5 years). See the *Replacement Rule* provision.
- Inlays/Onlays
- Crowns(limited to: 1 tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
- Post and core
- Core build-up

Prosthodontics

- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 5 years old.

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

(See the *Tooth Missing But Not Replaced* Rule.)

- Replacement of existing bridges or dentures (limited to: 1 every 5 years.) (See the *Tooth Missing But Not Replaced* Rule.)
- Bridge abutments (See Inlays/Onlays and Crowns)
- Pontics (limited to: 1 tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable Bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible)
  - Complete upper denture
  - Complete lower denture
  - Immediate upper denture
  - Immediate lower denture
  - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Pediatric fixed partial denture
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Occlusal analysis
  - Occlusal guard
  - Office reline
  - Laboratory reline
  - Precision attachments
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
    - Each tooth
    - Each clasp
- Repairs: crowns, bridges and fixed partial dentures
- Fixed partial denture sectioning
- Occlusal analysis
- Occlusal guard

General Anesthesia, Intravenous Sedation and Non-intravenous Sedation

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure
- Local anesthesia (not in conjunction with surgical procedures)

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

- Analgesia

Orthodontic services
Medically necessary comprehensive orthodontic treatment

- Replacement of retainer (limited to: 1 per lifetime)

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

Covered Benefits	Deductible/Copayment/Coinsurance/ Maximums
8. Outpatient Prescription Drugs	
Outpatient Prescription Drug Deductible, if any **A separate Deductible applies to Prescription Drugs.**	
You have to meet the **Deductible** before this plan pays for benefits.	
Individual	$0 per **Calendar Year**
Family	$0 per **Calendar Year**
Deductible waiver	
The **Calendar Year Prescription Drug Deductible**, if any, is waived for all **Preferred Tier 1A-Value Drugs** and **Generic Prescription Drugs** filled at a **Retail Pharmacy** and a **mail order pharmacy.**	
Deductible and Copayment or Coinsurance waiver for risk reducing breast cancer drugs	
The **Calendar Year Prescription Drug Deductible** and the per **prescription Copayment** or **Coinsurance** will not apply to risk reducing breast cancer **Prescription Drugs** when obtained at a N**etwork** P**harmacy**. This means that such risk reducing breast cancer **Prescription Drugs** will be paid at 100%.	
Deductible and Copayment or Coinsurance waiver for contraceptives	
The **Calendar Year Prescription Drug Deductible** and the per **Prescription Copayment** or **Coinsurance** will not apply to female contraceptive methods when obtained at a N**etwork** P**harmacy**. This means that such contraceptive methods will be paid at 100% for: • The following female oral and injectable contraceptives that are **Generic Prescription Drugs**: - Oral drugs - Injectable drugs - Vaginal rings - Transdermal contraceptive patches • Female contraceptive devices that are generic devices and brand-name devices • FDA approved female: - Generic emergency contraceptives - Generic over-the-counter (OTC) emergency contraceptives The **Calendar Year Prescription Drug Deductible** and the per **Prescription Copayment** or **Coinsurance** continue to apply to **Prescription Drugs** that have a generic equivalent, biosimilar or generic alternative available within the same **Therapeutic Drug Class** obtained at a N**etwork Pharmacy** unless you are granted a medical exception.	

Covered Benefits	In-network coverage
Per prescription Copayment or Coinsurance	
Tier 1A – Value Drugs	
For each 30 day supply filled at a **Retail Pharmacy**	Not covered
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Not covered
Tier 1 -- Preferred Generic Prescription Drugs	
For each 30 day supply filled at a **Retail Pharmacy**	0% after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	0% after **deductible**
Tier 2 -- Preferred Brand-Name Prescription Drugs	
For each fill up to a 30 day supply filled at a **Retail Pharmacy**	0% after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	0% after **deductible**
Tier 3 -- Non-Preferred Generic and Brand-Name Prescription Drugs	
For each 30 day supply filled at a **Retail Pharmacy**	0% after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	0% after **deductible**
Tier 4 -- Preferred Specialty Care Prescription Drugs(Including Biosimilar Prescription Drugs)	
For each 30 day supply filled at a **Specialty Network Pharmacy**	0% after **deductible**
Tier 5 – Non-Preferred Specialty Care Prescription Drugs(Including Biosimilar Prescription Drugs)	
For each 30 day supply filled at a **Specialty Network Pharmacy**	0% after **deductible**
Diabetic Prescription Drugs, Supplies and Insulin	
For each 30 day supply filled at a **Retail Pharmacy**	Paid according to the tier of drug per the Schedule of Benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the Schedule of Benefits, above
Orally Administered Anti-Cancer Medications	
For each initial 30 day supply filled at a **Specialty Network Pharmacy** and 30 day refill at a **Specialty Network Pharmacy**	The member will not pay more than $100 per **Prescription** for orally administered chemotherapy **Prescription Drugs**
Outpatient Prescription Contraceptive Drugs and Devices	
Female contraceptives that are **Generic Prescription Drugs.** For each 30 day supply: • Oral drugs • Injectable drugs • Vaginal rings	0% per **prescription** or refill

*See *How to read the Schedule of Benefits* at the beginning of this Schedule of Benefits

• Transdermal contraceptive patches	
Female contraceptives that are **brand-name Prescription Drugs.** For each 30 day supply: • Oral drugs • Injectable drugs • Vaginal rings* • Transdermal contraceptive patches	Paid according to the tier of drug per the Schedule of Benefits, above *Brand-name vaginal rings covered at 100% to the extent that a generic is not available
Female contraceptive **generic** devices and **brand name** devices. For each 30 day supply	0% per **prescription** or refill
FDA-approved female **generic** and **brand-name** emergency contraceptives. For each 30 day supply	0% per **prescription** or refill
FDA-approved female **generic** and **brand-name** over-the-counter emergency contraceptives. For each 30 day supply	0% per **prescription** or refill
Preventive Care Drugs and Supplements	
For each 30 day supply filled at a **Retail Pharmacy**	0% 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 the Aetna Navigator® secure website at www.aetna.com or calling the number on the back of your Membership ID card.	
Risk Reducing Breast Cancer Prescription Drugs	
For each 30 day supply filled at a **Retail Pharmacy**	0% 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 risk reducing breast cancer **prescription drugs**, contact Member Services by logging onto the Aetna Navigator® secure website at www.aetna.com or calling the number on the back of the your **Membership** ID card.	
Important note: See the *Outpatient prescription contraceptive drugs and devices, Preventive care drugs and supplements and Risk reducing breast cancer prescription drugs* section for more information on other **Prescription Drug** coverage under this plan.	
If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **Generic Prescription Drug** equivalent is available, you will be responsible for the cost difference between the **Generic Prescription Drug** and the **Brand-Name Prescription Drug**, plus the cost sharing that applies to **Brand-Name Prescription Drug**. The cost difference that you pay is not applied towards your **Calendar Year Prescription Drug Deductible**, if any, or **Maximum Out-of-Pocket Limit**.	