Employer:	Yeshiva University
Contract number:	MSA-0143778
Plan name:	Choice POS II
Booklet:	1
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You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services, or categories of healthcare , participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

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

Your plan provides . These are:

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

For under the outpatient drug plan:

- You need a from the prescribing
- You need to show your ID card to the network pharmacy when you get a filled

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

For example:

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

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

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

include manual or electro acupuncture.

The following are not :

Acupressure

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

include emergency transport to a by a licensed ambulance:

To the first to provide

From one to another if the first can't provide the you need

When your condition is unstable and requires medical supervision and rapid transport

also include precertified transportation to a by a licensed ambulance:

From a to your home or to another facility if an ambulance is the only safe way to transport you

From your home to a if an ambulance is the only safe way to transport you; limited to 100 miles

When during a covered inpatient at a , or acute rehabilitation , an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not :

Ambulance services for routine transportation to receive outpatient or inpatient services

include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

Systematically change behavior

Are responsible for observable improvements in behavior

Applied behavior analysis may require by us. See the *How your plan works – Medical necessity and precertification* section.

Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association.

include services and supplies provided by a or for:

The diagnosis and treatment of autism spectrum disorder

Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

include the treatment of provided by a , , , or including:

Inpatient at the (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your in a , , or

Outpatient treatment received while not confined as an inpatient in a , , or , including:

- c Office visits to a or such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes consultation)
- c Individual, group, and family therapies for the treatment of
- c Other outpatient mental health treatment such as:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a
  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a
  - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
    - You are homebound
    - Your orders them
    - The services take the place of a in a or a , or you are unable to receive the same services outside your home
    - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
  - Electro-convulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Psychological testing
  - Neuropsychological testing
  - Observation
  - Peer counseling support by a peer support specialist (including consultation)

include the treatment of provided by a , , , , or as follows:

- Inpatient , at the (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your in a , , or .

Outpatient treatment received while not confined as an inpatient in a , , or , including:

- Office visits to a or such as a psychologist, social worker, or licensed professional counselor (includes consultation)
- Individual, group, and family therapies for the treatment of

Other outpatient treatment such as:

- Partial hospitalization treatment provided in a facility or program for treatment of provided under the direction of a
- Intensive outpatient program provided in a facility or program for treatment of provided under the direction of a
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your orders them
  - The services take the place of a in a or a , or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Ambulatory or outpatient which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist (including consultation)

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

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

The following are not :

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

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

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

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

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

are DME and the accessories needed to operate it when:

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

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

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

also include:

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

The following are not :

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

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

include only outpatient services to evaluate and stabilize an in a emergency room. You can get from or .

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

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

If both of the above conditions are met and you continue to stay in the (emergency admission) or receive follow-up care, these are not . Different benefits and requirements apply. Please

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

- You must essentially be confined to the home as an alternative to a hospital stay
- Your orders them
- The services take the place of a in a or a , or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are , home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a or social worker

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

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

Hospice care services provided by the

Obtaining sperm from a person not covered under this plan.

treatment when a successful pregnancy could have been obtained through less costly treatment.

treatment when either partner has had voluntary sterilization , with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

treatment when is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period.

Treatment for dependent children.

Injectable medication, including but not limited to menotropins, hCG, and GnRH agonists.

include the diagnosis and surgical treatment of by a , including:

The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome

The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

The following are not :

Non-surgical medical and dental services, and therapeutic services related to

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

No less than 48 hours of inpatient care in a after a vaginal delivery

No less than 96 hours of inpatient care in a after a cesarean delivery

A shorter , if the attending , with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care .

also include services and supplies needed for circumcision by a .

The following are not :

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

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Obesity is a type of procedure performed on people who are morbidly obese for the purpose of losing weight. Your will determine whether you qualify for obesity .

include:

An initial medical history and physical exam
Diagnostic tests given or ordered during the first exam
Outpatient drugs included under the *Outpatient prescription drugs* section
An obesity
A multi-stage procedure when planned and approved by the plan
Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not

Weight management treatment
Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the booklet.
Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of ADA 11 Tf 7[-)]TJ /FAAABA 11 Tf [1324(Hypn)-1(osi)-1(s,)1(o)-1(r)1( )-1(other)1( )

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

- At the office
- In your home
- In a
- From any other inpatient or outpatient facility
- By way of

For behavioral health services, all in-person, with a are also if you use instead. may have a different cost share from other services. See your schedule of benefits.

Other services and supplies that your may provide:

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

include the following services provided by your :

- Abortion, where permitted by state and local laws.

prescriptio

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

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

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

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

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

A network pharmacy	The plan cost share
An out-of-network pharmacy	The full cost of the

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

- You will fill out and send a drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation

include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine
- Blood glucose meters and insulin pumps

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

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

include synthetic ovulation stimulant drugs used to treat the underlying medical cause of .

include drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

You must be diagnosed by your , including a physical exam and outpatient diagnostic lab work, with one of the medical conditions listed here:

- Morbid obesity
- Obesity with one or more of the following obesity-related risk factors:
  - Coronary artery disease

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

include FDA approved and OTC drugs to help stop the use of tobacco products.
You must receive a from your and submit the to the pharmacy for processing.

The following are not

Injectables including:

Any charges for the administration or injection of drugs

Needles and syringes except for those used for insulin administration

Any drug which, due to its characteristics as determined by us, must typically be administered or

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

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

Evidence-based items that have in effect a rating of A or B in the current recommendations of the

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

Your reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:

on a healthy breast to make it symmetrical with the reconstructed breast

Treatment of physical complications of all stages of the mastectomy, including lymphedema

Prostheses

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

Your is to implant or attach a covered prosthetic device.

Your corrects a gross anatomical defect present at birth. The will be covered if:

The defect results in severe facial disfigurement or major functional impairment of a body part

The purpose of the is to improve function

Your is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your will improve function.

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

The teeth were stable, functional and free from decay or disease at the time of the injury.

The or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

The first placement of a permanent crown or cap to repair a broken tooth

The first placement of dentures or bridgework to replace lost teeth

Orthodontic therapy to pre-position teeth

include cardiac rehabilitation services you receive at a , or office, but only if those services are part of a treatment plan determined by your risk level and ordered by your .

include pulmonary rehabilitation services as part of your inpatient if they are part of a treatment plan ordered by your . A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a , , or office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your .

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

Licensed or certified physical, occupational, or speech therapist

, , or hospice facility

include:

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

include:

Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or

for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your

We designate facilities to provide GCIT services or procedures. GCIT , and other are GCIT-designated facilities/ for Aetna and CVS Health.

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

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

- A freestanding outpatient facility
- The outpatient department of a
- A office
- Your home from a home care

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

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

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

include the following radiology services provided by a :

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

include transplant services provided by a and .

This includes the following transplant types:

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

also include:

Travel and lodging expenses

If you are working with an IOE facility that is 100 or more miles away from where you live, travel and lodging expenses are for you and a companion, to travel between home and the IOE facility

Coach class air fare, train or bus travel are examples of

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network , , , and limits, unless stated differently in this booklet and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network , , , , and limits, unless stated differently in this booklet and schedule of benefits

If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

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

include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening

The following are not under your plan:

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most

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

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

The following are not :

Services normally covered under a dental plan
Dental implants

Examples of these are:

Any service or supply for education, training or retraining services or testing. This includes:

- Special education
- Remedial education
- Wilderness treatment programs (whether or not the program is part of a or otherwise licensed institution)
- Job training
- Job hardening programs

Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Any health or dental examinations needed:

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

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

Routine services and supplies for the following:

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

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

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

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

Any cost resulting from a canceled or missed appointment

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins

  vitamins
- Medical foods
- Other nutritional items

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

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

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

Outpatient or non- and medicines
except as stated in the *Coverage and exclusions* section.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Some state or local laws restrict the scope of health care services that a may render. In such cases, the plan will not cover such health care services.

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

Non-emergency medical services, outpatient

drugs or supplies received outside of the United

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

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

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

Our is there to give you the care you need. You can find and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also contact us to ask for a copy of the directory. We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the network. See the Contact us section for more information.

You may choose a to oversee your care. Your

We encourage you to get through a . They will provide you with primary care.

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

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

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

You may change your at any time by contacting us.

You can also get care from . When you use an , your cost share is higher. You are responsible for:

- Your out-of-network
- Your out-of-network
- Any charges over the
- Submitting your own claims and getting

You may have to find a new when:

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

However, in some cases, you may be able to keep going to your current or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the or facility ceasing to be in our network. This is called continuity of care. If we know you are under an active treatment plan, we will notify you of the or facility's contract termination and how you can submit a request to keep going to your current or facility. Contact us for additional information.

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

We cover , sex-specific regardless of identified gender.

You need pre-approval from us for some . Pre-approval is also called .

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

When you go to an , you are responsible to get any required from us. If you don’t :

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

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

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

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

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

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

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

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

- Call the toll-free number on your ID card
- Log in to the Aetna website at https://www.aetna.com/
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

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

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

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

- You pay the , when it applies.
- Then the plan and you share the expense. Your share is called a or .
- Then the plan pays the entire expense after you reach your .

When we say "expense" in this general rule, we mean the for a , and for an .

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

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

We may enter into arrangements with or others related to:

- The coordination of care for members
-

If your claim is not paid as outlined above, the for specific services or supplies will be the , calculated in accordance with the following:

Professional services*	The reasonable amount rate
Inpatient and outpatient charges of	The reasonable amount rate
Inpatient and outpatient charges of facilities other than	Facility Charge Review
	110% of the average wholesale price (AWP)

**Involuntary services are not paid as outlined above. See Involuntary Services and Surprise Bills for information on how these claims are paid under the plan.*

: If the bills less than the amount calculated using the described above, the is what the bills.

In the event you receive a balance bill from a for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances. If Patient Advocacy Services are available for your claim, additional information will be provided to you.

If NAP does not apply to you, the for specific services or supplies will be the out-of-network plan rate set forth in the above chart.

The out-of-network plan rate does not apply to involuntary services. See *Involuntary Services and Surprise Bills* for more information.

Special terms used

Average wholesale price (AWP) is the current average wholesale price of a listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by).

Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility estimated costs for the service and leave the with a reasonable profit. This means for:

and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS

Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the . For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific performance. We update our system with these when revised within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:

- The method CMS uses to set Medicare rates
- How much other providers charge or accept as payment
- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to or other and backdated adjustments
- For anesthesia, our rate may be at least 100% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes.

"Reasonable amount rate" means your plan has established a reasonable rate amount as follows:

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

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

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Surgical or ancillary services mean any professional services including:

, including assistants

Anesthesiology

Pathology

Radiology

Hospitalist services

Laboratory services

Neonatology

Emergency Medicine

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

- The service is
- You get your care from a
- You or your the service when required

For coverage:

- The service is
- You get your care from an
- You or your the service when required

For outpatient drugs, your costs are based on:

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

The plan may make some available to you at the cost share.

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

You pay the entire expense when:

- You get services or supplies that are not .
- Your plan requires , your requests it, we deny it and you get the services without .
- You get care and the waives all or part of your cost share.

In all these cases, the may require you to pay the entire charge. Any amount you pay will not count towards your or your .

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

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

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

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

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

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

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

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

When this is your primary plan, we pay your medical claims first as if there is no other coverage.

When this is your secondary plan:

- We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
- Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
- Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
    - The amount that the secondary plan saved due to COB
    - Used to cover any unpaid allowable expenses
    - Erased at the end of the year

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

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current and prior plan must be offered through the same employer.

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

We have the right to:

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

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

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

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

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

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we them. We will make a decision within 15 days.

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

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a or adding a number of visits to a . You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

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

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

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

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

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

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

You may not be happy about a or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint We will let you know if we need more information to make a decision.

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

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

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

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

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

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60

If your claim is an urgent claim or a pre-service claim, your may appeal for you without having you fill out an authorized representative form telling us that you are allowing the provider to appeal for you.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

In most situations you must complete the two levels of appeal with us before you can take these other actions:

Appeal through an external review process.

Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.

External review is a review done by people in an organization outside of . This is called an external review organization (ERO).

You have a right to external review only if:

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

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

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

You must submit the Request for External Review Form:

- To
- Within 123 calendar days (four months) of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

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

will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.

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

But sometimes you can get a faster external review decision. Your must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

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

Your tells us that a delay in your receiving health care services would:
Jeopardize your life, health or ability to regain maximum function
Be much less effective if not started right away (in the case of treatment), or
The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received , but have not been discharged from a facility

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

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

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

Your employer decides and tells us who is eligible for health coverage.

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

You can enroll:

- At the end of any waiting period your employer requires
- Once each year during the annual enrollment period

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

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

You can also enroll in these situations:

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

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

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

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

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

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

Dependent coverage will end if:

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

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

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

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

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

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

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

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

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before

We prepared this booklet according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage.

Aetna will administer the Plan in accordance with this booklet and apply policies and procedures which Aetna has developed to administer this plan.

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

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

Aetna has been designated as claims administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

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

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

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

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

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

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

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

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

You have special rights if we rescind your coverage:

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

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

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

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

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for if it violates a financial sanction suor example, we cannot pay fmple4m1fcan hconomiA 11Tm [su)-11(o)3-1 0 10.47(tt vssad)-1cia]TJ .vsor ehmidv70al l b

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

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

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

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

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from

A who is licensed or certified to provide for mental health and in the state where the person practices.

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

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

The benefits, subject to varying cost shares, covered under the plan. These are:

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

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

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

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

freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a and provides .

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

A drug, device, procedure, or treatment is if:

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

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

- Dosage
- Safety
- Strength
- Quality
- Performance

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

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

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

A , pharmacist, , person, or facility, licensed or certified by law to provide health

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

A facility specifically licensed as a by appcall

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

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

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

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

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a :

- Ambulatory surgical center
- Emergency room
- Outpatient department of a office
- Urgent care facility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website,

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

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

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you