Re: Group Number 0803918

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

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

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

We appreciate your business.

Sincerely,

aetna® *

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

AETNA HEALTH OF CALIFORNIA INC.

Group agreement

The HMO group agreement is by and between

AETNA HEALTH OF CALIFORNIA INC. and
NIAGARA BOTTLING LLC
Contract holder

Group agreement number: 0803918
Effective date: January 01, 2021
Contract situs: California

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

Term of the HMO group agreement:

- The initial term is the 12 consecutive months beginning on the **effective date**.
- Subsequent terms are the 12 consecutive months beginning with the **renewal date**.

Premium due dates: The **effective date** and each month after that**.**

Signed at **Aetna's** Home Office 1385 East Shaw Ave, Fresno, CA 93710.

This group agreement is governed by applicable federal law and the laws of California.

By: Gregory S. Martino

Gregory S. Martino
Vice President

NOTICE

If you have a question or concern, you can contact your agent or broker or contact us at the number and address shown below:

Customer Service
Aetna Health of California, Inc.
1385 East Shaw Ave.
Fresno, CA 93710

You may also contact the California Department of Managed Health Care with your concerns. You can contact them at:

California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
Fax: 916-255-5241
TDD: 1-877-688-9891

Table of contents

The HMO group agreement

The HMO group agreement is the entire contract between us. Any statement that a **covered person** or you make in the group application is, in the absence of fraud, deemed a representation and not a warranty. The HMO group agreement consists of the following documents:

- Your group application
- This group agreement
- The EOC(s)
- The schedule of benefits
- Riders and amendments

If you want to discuss your coverage

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

AETNA HEALTH OF CALIFORNIA INC.
1385 East Shaw Ave
Fresno, CA 93710

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

Definitions

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

Contract holder

NIAGARA BOTTLING LLC and entities associated with it for purpose of coverage under this group agreement.

Covered person

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

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

Dates:

Effective date

Date we first cover you under this group agreement.

Final rates and fees schedule effective date

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

Premium due date

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

Renewal date

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

Termination date

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

Premium

Premium – rates and amount due

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

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

You owe premium for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying premium for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – individual proration

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

Premiums shall be adjusted as outlined below for persons whose:

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

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

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

Premium – changes in rates

We may change the premium rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We will explain these changes in factors in our rate quote to you
- There is a change in federal and state laws or regulations, or there is a judicial decision, that materially affects the cost of providing coverage

We may change the premium rates as of a **premium due date** during any following term.

We will let you know in writing of any change in premium rate 30 days before they take effect.

Premium – experience credit

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

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

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

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

Premium – when due

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

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

Premium – how billed and paid

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

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

Premium – overdue amounts

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

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

Premium – eligibility corrections

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

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

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

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

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

Premium – waiver

Payment of premiums

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

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

Repayment of the waived premium

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

Fees for special services and assessments

Special services

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

The special services are:

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

Special services – fees

The *Final rates and fees schedule* lists the special service fees. We may change any fee on 30 days advance notice to you. We will provide you with a new *Final rates and fees schedule* when the amount of any fee changes. The new schedule will state its **effective date**.

Payment for third party technology provider

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

Assessments

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

Fees and assessments – when due

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

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

Fees and assessments – how billed and paid

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

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

Fees and assessments – overdue amounts

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

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

Some of our other responsibilities

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

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

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers**' claims and otherwise help us administer the group agreement. For a copy of our Notice of Privacy Practices log on to https://www.aetna.com/.

Our duties in this section survive termination of the group agreement.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

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

You shall distribute two documents required by the federal ACA:

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

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

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

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

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

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

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

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

Distribution – EOC and schedule of benefits

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

Information – access

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

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

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

Information – eligibility

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

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

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

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

You shall:

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

We will not start covering a person under the group agreement until you send us the information to enroll that person. Subject to applicable federal and state laws and the group agreement, we will not stop covering a person until you send us the information to terminate coverage.

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

- An employee's employment ceases
- A dependent loses eligibility under the group agreement

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

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

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

90 day waiting period limitation

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the ACA. We will not impose our own waiting period.

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

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

Notices – termination of coverage

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

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

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

You will give the notification within 30 calendar days to a person becoming eligible for continuation coverage.

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

Workers' compensation coverage

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

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

Termination

Guaranteed Renewable

Subject to any applicable rules, regulations or other standards set forth by the Department, this group agreement is guaranteed renewable at premium rates set by us. However, we may refuse renewal under certain conditions, as explained below. We will send you a renewal notice 60 days prior to the renewal date.

Automatic termination

The group agreement and all coverage end as of the last day of the grace period if you have not paid us all premiums and fees and assessments due as of the beginning of the grace period. The *Premium* section has a description of the grace period.

Termination by you

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

Termination by us

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

- Immediately upon notice to you:
  - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
  - If you no longer have any employees under the plan who live, or work in the service area
  - If you are a member of an association and your membership in the association ceases

- Upon 30 days written notice to you:
  - If you breach a material provision of the group agreement and you do not cure the breach within the notice period
  - If you cease to be a group as defined under applicable state law
  - If you fail to meet our contribution or participation requirements applicable to this group agreement
  - If you change your participation requirements without our consent

- Upon 90 days written notice to you and the Director at the Department of Managed Health Care (or such longer notice period as applicable federal and state laws require,) if we cease to offer the product provided by this group agreement

- Upon 180 days written notice to you and the Director at the Department of Managed Health Care (or such longer notice period as applicable federal and state laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage

Special rights on termination of the group agreement

A **covered person** has special rights that may apply when we terminate the HMO Agreement and its coverage. Your special rights are:

- The **covered person** has the right to an **Aetna** appeal
- The covered person has the right to request a review by the Director of the California Department of Managed Health Care

Non-renewal for failure to respond

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

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

whichever is later.

You must reply in writing unless we authorize an oral reply. If you do not reply, we will not continue coverage on and after the **renewal date** and:

- You owe us any unpaid premium
- We owe you a refund if you overpaid premium

Effective time of termination

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

Effect of termination

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

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

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

Reinstatement

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

Fraud and intentional misrepresentation

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

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

We also may report fraud to law enforcement. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

We may rescind the group agreement and all coverage for fraud or intentional misrepresentation of material fact upon written notice, via certified mail at least 30 days prior to the effective date of the rescission of coverage. The notice will state the effective date of rescission, the reasons we are rescinding the coverage, and your right to appeal to the California Department of Managed Health Care.

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

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

We will not rescind your agreement for any reason after your coverage has been in force for 24 months.

Responsibility for conduct

Employees and agents

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

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

Termination of network providers

We will notify you, if it will adversely or materially affect you or any **covered person**, of a network provider:

- Termination

- Breach of contract
- Inability to perform

You will let your employees know about this notice no later than 30 days after its receipt.

Indemnification – in general

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

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your:

- Negligence
- Breach of the group agreement
- Breach of applicable federal and state laws
- Willful misconduct
- Criminal conduct
- Fraud
- Breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this group agreement or your role as employer or Plan Sponsor, as defined by ERISA.

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

Indemnification – federal law requirements

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

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

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

Your and our rights and duties in this section survive termination of the group agreement.

General provisions

General provisions – content and interpretation of the group agreement

Applicable law

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

Compliance with law

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

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

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

We are subject to the requirements of Chapter 2.2 of Division 2 of the Code and of Chapter 1 of Title 28 of the California, and any provision of Regulations required to be in the group agreement by either of the above shall bind us whether or not provided in the group agreement.

Changes to the group agreement

We may both consent to amend the group agreement in writing.

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

We have to give you 90 days advance written notice, and you have to consent in writing to changes in the group agreement that:

- May reduce benefits or coverage
- May eliminate benefits or coverage
- May increase benefits or coverage with a concurrent increase in premium during the current group agreement term, other than increased benefits or coverage required by federal and state laws

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

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

Entire agreement

The group agreement replaces and supersedes:

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

Waiver

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

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

General provisions – administration of the group agreement

Aetna name, symbols, trademarks and service marks

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

Assignment and delegation

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

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

Claim determinations – ERISA claim fiduciary

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

- To review whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the group agreement

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

- An individual's claim history
- A provider's billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

We may correct, withdraw, or replace the group agreement, any EOC, any schedule of benefits and any other document issued with an error or issued in error. We will make a fair adjustment in premium if correction of the error or any delay changes coverage.

Correcting your honest mistakes

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

Discrimination prohibited

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

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

Financial Sanctions Exclusions

If coverage provided by this group agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we 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 permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Notices

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

Notice may be delivered:

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

Mail notices to us by mail and commercial carrier:
AETNA HEALTH OF CALIFORNIA INC.
1385 East Shaw Ave
Fresno, CA 93710

We will send notices to you by mail and commercial carrier:
NIAGARA BOTTLING LLC
1440 BRIDGEGATE DRIVE
DIAMOND BAR, CA 91765

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

Policies and procedures

You and all **covered person**s are bound by and shall comply with our policies and procedures. You will certify your compliance with them upon our request or as required specifically by the group agreement.

Third parties rights

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

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

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

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

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

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

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

Language Assistance

TTY: 711

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပှ့ၤလၢကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ဘၣ်နှၣ် ကိး 1-888-982-3862 တက့ၢ်. (Karen)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ܐܢ ܣܢܝܩܐ ܝܗܘܢ ܠܗ ܝܠܦܬܐ ܕܬܘܪܓܡܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ، ܡܚܒܪ ܠ:
(Syriac-Assyrian) 1-888-982-3862
మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి. (Telugu)

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

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

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

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

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

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

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

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

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

HMO

Health maintenance organization (HMO)
Evidence of coverage

Prepared exclusively for:
Contract holder: NIAGARA BOTTLING LLC
Contract holder number: 0803918
Group agreement effective date: January 01, 2021
Plan effective dates: January 01, 2021

Underwritten by Aetna Health of California Inc. in the State of California

Table of contents

Welcome

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

Welcome to Aetna.

This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Introduction

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan that includes:

- **Family planning**
- **Contraceptive services, including emergency contraception**
- **Sterilization, including tubal ligation at the time of labor and delivery**
- **Infertility treatments**
- **Abortion**

Call your prospective provider or contact us for help if you have any questions.

How we use words

When we use:

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

Contact us

Your plan includes the Aetna concierge program. It provides immediate access to consultants trained in the specific details of your plan.

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

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at https://www.aetna.com/
- Writing us at 1385 East Shaw Ave, Fresno, CA 93710

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

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

Your ID card

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

Wellness and other rewards

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

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

Timely access to care

We have standards for timely access to care and reasonable appointment wait times. These include:

- Urgent care within 48 hours of the request
- Non-urgent primary care within 10 business days of the request
- Non-urgent specialty care within 15 business days of the request
- Telephone screening within 30 minutes of the request

We may have exceptions to appointment wait times when the Department of Managed Health Care allows such exceptions. Interpreter services will be made available to you at the time of your appointment.

If you have a complaint, because you cannot access medical care in a timely manner, you can contact us at the number shown on your ID card. You can also write to us at:
Customer Service
Aetna Health of California, Inc.
1385 East Shaw Ave.
Fresno, CA 93710

You may also contact the California Department of Managed Health Care with your concerns. You can contact them at:
California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219
Fax: 916-255-5241
TDD: 1-877-688-9891

Coverage and exclusions

Providing covered services

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

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

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

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

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

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

Important note:
All medically necessary services for a severe mental illness (SMI) or a serious emotional disturbance of a child (SED) shall be covered regardless of any exclusions or limitations described in the EOC.

Acupuncture

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

Covered services also include services performed to alleviate, treat, or limit:

- Chronic pain
- Postoperative and chemotherapy-induced nausea and vomiting
- Nausea during pregnancy
- Postoperative dental pain
- Temporomandibular disorders (TMD)
- Migraine headache
- Pain from osteoarthritis of the knee or hip

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency

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

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

Non-emergency

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

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

The following are not **covered services**:

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

Clinical trials

Routine patient costs

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

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

"Routine patient costs" include:

- Health care services provided absent a clinical trial
- Health care services required solely for the provision of the investigational drug, item, device, or service
- Health care services required for the monitoring of the investigational item or service
- Health care services provided for the prevention, diagnosis, or treatment of complications from the provision of the investigational drug, item, device, or service
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service (including diagnosing and treating complications)

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself

Experimental or investigational therapies

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

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

An approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Dental care anesthesia

Covered services include anesthesia for dental care, that your doctor has certified, cannot be performed in the dentist's office due to age or condition of the covered person.

Diabetic services, supplies, equipment, and education

Covered services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Injection devices including syringes, needles and pens
  - Test strips - blood glucose, ketone and urine
  - Blood glucose calibration liquid
  - Lancet devices and kits
  - Alcohol swabs
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Education
- Self-management training provided by a health care **provider** certified in diabetes self-management training

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

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

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

Covered services also include:

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

The following are not **covered services**:

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

Emergency services

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

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

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the

How your plan works – Medical necessity, referral and precertification requirements section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician** (**PCP**).

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

The following are not **covered services**:

- Non-emergency care in a **hospital** emergency room

Foot orthotic devices

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

Gender reassignment

Covered services include **medically necessary** gender reassignment services, including, but are not limited to, the following services:

- Hormone therapy
- Hysterectomy
- Mastectomy
- Vocal training

These services will not be denied if you enrolled as a member of the opposite sex or are in the process of a gender transition.

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

The following are not **covered services**:

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

Hearing exams

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

The following are not **covered services**:

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

Home health care

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

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

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

The following are not **covered services**:

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

Hospice care

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

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

- Bereavement counseling
- Respite care

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge.
- Services of **physicians** employed by the **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.

Important note:
All medically necessary services for a severe mental illness (SMI) or a serious emotional disturbance of a child (SED) shall be covered regardless of any exclusions or limitations described in the EOC.

The following are not **covered services**:

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

Infertility services

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

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- To perform standard fertility preservation procedures due to iatrogenic **infertility.**

The following are not **covered services**:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, professional services.
- Intrauterine/intracervical insemination services.

- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue, unless due to iatrogenic **infertility.**
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.

Jaw joint disorder treatment

Covered services include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider**, including:

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

The following are not **covered services**:

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

Maternity and related newborn care

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

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

Covered services also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

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

Mental health treatment

Covered services include the treatment of **mental disorders**, including those that are defined as severe mental illnesses and/or serious emotional disturbances of a child, and that are provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician,** or **behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (Your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental disorders**
  - All other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Behavioral health treatment for pervasive developmental disorder or autism
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation
    - Peer counseling support by a peer support specialist

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

Important note:
All medically necessary services for a severe mental illness (SMI) or a serious emotional disturbance of a child (SED) shall be covered regardless of any exclusions or limitations described in the EOC.

Severe mental illness means the following:

- Anorexia/bulimia nervosa

- Bipolar disorder
- Major depressive disorder
- Obsessive compulsive disorder
- Panic disorder
- Pervasive developmental disorder (including autism)
- Psychotic disorders/delusional disorder
- Schizo-affective disorder
- Schizophrenia

A child suffering from serious emotional disturbances means a child who:

- Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (other than a primary substance use disorder or developmental disorder)
- Has inappropriate behavior for the child's age according to expected developmental norms
- Meets the criteria in California's Welfare and Institutions Code

Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore the functioning of any individual with pervasive developmental disorder or autism. Behavioral health treatment must:

- Be prescribed by a **physician** or psychologist
- Be provided under a treatment plan prescribed by a qualified autism service provider
- Be administered by qualified autism service providers, qualified autism service professionals or qualified autism service paraprofessionals

The treatment plan must:

- Have measurable goals
- Be reviewed at least every six months
- Change whenever appropriate
- Describe the conditions that need to be treated
- Include the service type, number of hours, and parent participation needed
- End when treatment goals are met or no longer appropriate

A treatment plan is not used for **custodial care** or educational services. We can ask for a copy of the treatment plan.

The following services require **precertification**:

- Behavioral health treatment for pervasive developmental disorder or autism
- Inpatient admissions
- Intensive outpatient programs
- Neuropsychological testing
- **Partial hospitalization treatment**
- Psychological testing
- **Residential treatment facility** admissions
- Skilled behavioral health services provided in the home

Important note:
You may still be eligible for services under state law, including the Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs.

Nutritional support

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

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

The following are not **covered services**:

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

  even if it is the sole source of nutrition.

Obesity (bariatric) surgery

Covered services include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are morbidly obese, for the purpose of losing weight. Obesity is typically diagnosed based on your body mass index (BMI). To determine whether you qualify for obesity surgery, your doctor will consider your BMI and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a BMI less than 35.
Your doctor will request approval from us in advance of your obesity surgery. We will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient prescription drug benefits included under the Outpatient prescription drug rider

Health care services include one bariatric surgical procedure. However, **covered services** also include a multi-stage procedure when planned and approved by us. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our network facilities that perform obesity surgeries.

Outpatient surgery

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

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

The following are not **covered services**:

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

Physician services

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

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

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

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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

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

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

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

- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

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

Family planning services – female contraceptives

Covered services include family planning services as follows:

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

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

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

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

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

Covered services also include participation in the California Prenatal Screening Program. The State Department of Health Services administers this program.

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms

- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

Reconstructive surgery and supplies

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

- Your **surgery** corrects or repairs abnormal structures of your body caused by:
  - Congenital defects
  - Developmental abnormalities
  - Trauma
  - Infection
  - Tumors
  - Disease
  - Cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate (includes necessary dental or orthodontic services)
- Your **surgery** will improve function or create a normal appearance
- There are no other more appropriate surgical procedures
- Your **surgery** offers more than a minimal improvement in your appearance

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the Short-term rehabilitation services section in the schedule of benefits.

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

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, without regard to whether there is physical cause
  (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

The following are not **covered services**:

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

Skilled nursing facility

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

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

Substance related disorders treatment

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

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

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

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. Chemotherapy is covered as outpatient care when received in an outpatient setting. There may be separate charges for the chemotherapy drugs and a facility fee for the administration. Chemotherapy administered during a hospital stay is covered as an inpatient benefit.

Infusion therapy

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

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

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

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**. **Urgent conditions** need prompt medical attention but are not life-threatening.

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

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

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

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Adult vision care

Covered services include:

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

The following are not **covered services**:

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

Pediatric vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

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

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

General plan exclusions

Important note:
All medically necessary services for a severe mental illness (SMI) or a serious emotional disturbance of a child (SED) shall be covered regardless of any exclusions or limitations described in the EOC.

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

Behavioral health treatment

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

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

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

Examples of these are:

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

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections

Court-ordered services and supplies

Includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan

Custodial care

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

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

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

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Non-diabetic services and supplies for the following:

- The treatment of calluses, bunions, toenails, hammertoes or fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes

Growth/height care

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

Hearing aids

- Any tests, appliances and devices to:
  - Improve your hearing
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Mental health and substance use disorders treatment

The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions, Preventive care* section
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

Missed appointments

Any cost resulting from a canceled or missed appointment

Obesity surgery and services

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

- Liposuction
- Stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements and appetite suppressants
- Hypnosis, or other forms of therapy

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

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Private duty nursing

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

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

Strength and performance

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

Telemedicine

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

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment

- Sensory or hearing and sound integration therapy

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

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

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

How your plan works

How your plan works while you are covered

Your HMO plan:

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

Please read the following information so you will know from whom or what group of provider's health care may be obtained.

Providers

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

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

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

Service area

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

Who provides the care

Network providers

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

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

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

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

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

Your PCP

You must get **covered services** through your **PCP**'s office. They will provide you with primary care.

How you choose your PCP

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

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

What your PCP will do for you

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

Your **PCP** will give you a written or electronic **referral** to see other **network providers**.

Changing your PCP

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

If you do not select a PCP

Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**. If you wish, you can change the **PCP** by following the directions above for changing your **PCP**.

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

How is my PCP paid?

Your **PCP** and other **providers** may be paid in any of the following ways, depending on their contract with us:

- A fixed price per service
- A fixed price per day
- A fee for each service set by a fee schedule
- A fixed monthly amount per member

Providers who contract with us have no requirement to comply with:

- Specified numbers
- Targeted averages
- Maximum duration for patient visits

We design our compensation arrangements to encourage our **providers** to provide the most appropriate care and to discourage unnecessary and potentially detrimental care.
When **providers** are paid a fixed monthly amount per member, we incorporate specific "quality factors" into the compensation process. These quality factors include:

- Appropriate diagnostic testing
- Specialty and **hospital** utilization
- Member satisfaction survey results
- Thoroughness of medical chart documentation

- Clinical care measures for diabetes, asthma and other conditions
- Number of scheduled office hours
- Range of office procedures offered
- Around the clock coverage
- Participation in continuing education programs

We encourage you to ask your PCP, us, your **provider**, or the **provider's** medical group or independent practice association how they are paid, including if their contracts include any financial incentives.

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

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

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network (for reasons other than imminent harm to patients, a determination of fraud, or a final state disciplinary action by a licensing board)

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

Care will continue during a transitional period that will vary based on your condition.

If you have this condition	The length of transitional period is
Acute condition	As long as the condition lasts
Serious chronic condition	No more than 12 months. Usually until you complete a period of treatment and your **physician** can safely transfer your care to another **physician**.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Terminal illness	As long as the person lives
Care of child under 3 years	Up to 12 months
An already scheduled **surgery** or other procedure	Within 180 days of you joining the Aetna plan or your **provider** leaving the network

Acute condition means:

- A condition that appears suddenly
- A problem that requires immediate medical care or mental health services and does not last long

Serious chronic condition means:

- A condition due to a disease or other medical or mental health problem
- A disorder that is serious and:
  - Continues without full cure
  - Worsens over time
  - Requires ongoing treatment to maintain remission or prevent deterioration

You or your **provider** should call us for approval to continue any care. You can also call Member Services at the number on the back of your ID card to get a copy of our policy on continuity of care.
Your claim will be paid at the **network provider** cost sharing level.

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

Medical necessity, referral and precertification requirements

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

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

Medically necessary, medical necessity

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

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

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

Referrals

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

Second Opinion

Covered services include a second opinion by a **physician** or other **health professional** whenever requested by your **provider**. Reasons for a second opinion include, but are not limited to, the following reasons:

- You are not sure if a recommended surgical procedure is reasonably necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- Your **physician** is unable to diagnose the medical condition and you request an additional diagnosis

- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have tried to follow a plan of care or asked your **physician** about serious concerns about the diagnosis or plan of care

Certification

We may need to certify certain services based on **medical necessity** before or during the delivery of certain inpatient and outpatient services. This pre-service or concurrent service review of **medical necessity** is described in the ***Precertification*** section below. We may also need to certify, as **medically necessary**, any services that were delivered in an emergency or urgent care situation; these are post-service certifications, which are described below.

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**. **Precertification** is required for certain **covered services** to determine whether a service is **medically necessary** before the service is provided.

If you seek care through a network **physician** or **PCP,** your network **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. Network **providers** cannot bill you if they fail to ask us for **precertification**. You are responsible for obtaining approval from us before you get care from any **out-of-network provider**. Timeframes for requesting **precertification** are listed below under ***Precertification Decisions***. To obtain **precertification**, contact us at the toll-free number on your ID card.

Precertification is not required for requests for emergency or urgent admissions, but you, your physician, or the facility should contact us within the timeframes shown below. You can contact us at the toll-free number on your ID card. The timeframes for non-emergency outpatient services and admission are also listed below.

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

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

We will tell you and your **physician** in writing of the **precertification** decision.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but

no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

Precertification Decisions

The list below includes the timeframes required for us to provide our decision to approve, deny or modify a request for **precertification** of a service and how and when we will convey that decision to you and your **provider**:

Type of Certification Request	Timeframes for Plan Certification Decisions	Timeframes for notifying You or your Provider
Urgent pre-service request	Decision will be made within 72 hours from receipt of request and all necessary information	We will make decision and notify you of the decision within 3 days
Non-urgent pre-service request	Decision will be made within 5 business days from receipt of request and all necessary information	We will notify your provider within 24 hours of the decision; decisions to deny, modify or delay request will be made in writing to you within 2 days of the decision
Urgent concurrent review request	Decision will be made within 72 hours from receipt of request and all necessary information	We will notify your provider within 24 hours of the decision
Non-urgent concurrent review request	Decision will be made within 5 business days form receipt of request and all necessary information	We will notify your provider within 24 hours of the decision; decisions to deny, modify or delay request will be made in writing to you within 2 days of the decision
Post-service or retrospective review request	Decision and notification will be made within 30 calendar days from receipt of the request	We will notify enrollee within 30 calendar days from receipt of the request

An approval is valid for 180 days as long as you remain enrolled in the plan. If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Grievances and Appeals* section.

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies which include but are not limited to the following:

Inpatient services	Outpatient services and supplies
Stays in a **hospital**	Complex imaging
Stays in a **skilled nursing facility**	Comprehensive **infertility** services
Stays in a **rehabilitation facility**	Reconstructive **surgery** and supplies
Stays in a **hospice** facility	Non-Emergency transportation by fixed wing airplane

Inpatient services	Outpatient services and supplies
Stays in a residential treatment facility for treatment of **mental disorders** and **substance related disorders**	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
Obesity (bariatric) **surgery**	ART services
	Kidney dialysis
	Outpatient back **surgery** not performed in a **physician's** office
	Private duty nursing services
	Sleep studies
	Knee **surgery**
	Wrist **surgery**

Visit our website at https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html or contact us at the toll-free number on your ID card to get a current list of the services that require **precertification**. The list may change from time to time.

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

Post-Service Certification

You do not need to obtain **precertification** for emergency services. However, you should contact us within 48 hours or as soon as reasonably possible after being admitted or after receiving care in the emergency department. For urgent care services, contact us before receiving urgent care or as soon as possible following an urgent care admission or treatment.

We may conduct a post-service certification review to determine whether the emergency or urgent care services were **medically necessary**. If we deny the emergency or urgent care service as being not **medically necessary**, you can submit a grievance. Please see the *Grievance and Appeals* section. If you paid for the emergency or urgent care services at the time the services were delivered, then you should submit a post-service claim to us. Please see the *Post-Service claims* section for additional information.

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

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

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

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

Some of these arrangements are called:

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

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

*For **prescription** drug services:*
When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third-party vendor that provided it. The **negotiated charge** may include additional service or risk charges and administrative fees. It doesn’t include any rebates or additional amounts paid to or received from third parties under price guarantees.

Paying for covered services – the general requirements

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

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

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

You pay the entire expense when:

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

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

If we fail to pay the **network provider**, you shall not be liable to the **network provider** for any sums that we owe.

Important exception-protection from surprise bills

A surprise bill is a bill you receive for eligible health services performed by an out-of-network physician or health professional at a network facility, or as a result of treatment at a network facility. For example, this may happen when:

- A network physician or health professional is unavailable at the time the eligible health services are performed
- An out-of-network physician or health professional performs services without your knowledge that the eligible health services would be performed or that the provider is out-of-network
- Unforeseen medical issues or services arise at the time the eligible health services are performed

A surprise bill does not include a bill for emergency services.

In the case of a surprise bill, you will pay the same cost share you would if the **covered services** were received from a **network provider** (the in-network cost share). The cost share will be based on the greater of:

- The average contracted rate
- 125% of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic area where the services were rendered

Any cost share you pay related to the surprise bill will count toward:

- Your in-network **deductible**, if any
- Your **copayments/coinsurance**
- Your in-network **maximum out-of-pocket limit**

An out-of-network **physician** or **health professional** can bill you the out-of-network cost sharing only when they get your consent. The consent must:

- Be in writing, at least 24 hours before the care is given, but not at the time of admission or when you are being prepped for any **surgery** or procedure
- Be in a separate document from your consent to treatment and in the language you speak
- Include a written estimate of total out-of-pocket cost of care
- Tell you that you can either seek care from an in-network **provider** or that you can contact us to arrange services from an in-network **provider** for lower out-of-pocket costs
- Tell you that the costs for treatment may not count toward the in-network **deductible** of in-network **maximum out-of-pocket limit**

Where your schedule of benefits fits in

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

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

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

Post-Service Claims

A claim is a request for payment that you or your health care **provider** submits to us to reimburse you for paying in whole or in part for the cost of health care services that have already been delivered to you, or to pay a bill issued by an out-of-network **provider** for the cost of health care services already delivered to you.

You or your health care **provider** would file a post-service claim:

- When you have received emergency or urgent care services, and you have paid for those services or the provider or facility has billed for those services
- When you have received services that require **precertification** or concurrent certification but you were either denied certification by us and obtained the services anyway, or you did not request precertification or concurrent certification from us before receiving the services, and you have paid for those services or the **provider** or facility has billed for those services
- When you receive services from an **out-of-network provider** and, you have paid for those services or the **provider** or facility has billed for those services.

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.

Filing a claim

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get:

- Online at http://www.aetna.com/ or
- Contact member services at the toll-free number on your ID card

You should always keep your own record of the date, **providers** and cost of your services.

Claim decisions and notifications

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

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

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 *Grievances and Appeals* section for that information.

When we make a decision to deny your post-service claim or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. See the Grievance and Appeals section for information on filing an appeal of an adverse benefit determination.

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
    - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
    - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
    - 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

Determining who pays

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

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

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

How COB works with Medicare

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

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

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

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Grievances and appeals

Grievances

A grievance is a written or oral expression of dissatisfaction regarding your plan and/or **provider**, including quality of care concerns. A grievance shall include a complaint, dispute, request for reconsideration or appeal made by you or your representative. You can contact us at any time at the number shown on your ID card.

You can also write to us at:
Customer Service
Aetna Health of California Inc.
1385 East Shaw Ave.
Fresno, CA 93710

Some reasons you may file a grievance include:

- You are dissatisfied with our decision to deny, modify, or delay your or your **provider**'s request for precertification of a service
- If we deny your post-service claim or reduce the amount of money we pay on your care or out-of-pocket expense, you can submit a grievance/appeal
- You are not satisfied with the quality of care you received
- Your **PCP** refused to provide a **referral** to a **specialist** or facility, and you are dissatisfied with the **PCP**'s decision
- You or your **provider** requested that we continue to certify a service and we denied certification for continuation of the service.
- We were not courteous or prompt when providing services to you
- You are dissatisfied with having to wait so long for an appointment with a **specialist** or for an inpatient or outpatient procedure
- We terminated your coverage and you think that decision is unfair

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the services you received.
You can submit a grievance by:

- Obtaining a grievance form from us or our website and submit the grievance in writing online or by mail, or
- Calling the toll-free number on your ID card and providing the grievance orally to us.

Standard (Non-Urgent) Grievance
Below are the timeframes and steps in how we process a grievance:

- We will send you an acknowledgment letter within 5 calendar days of receiving your grievance
- We will send a letter with our resolution within 30 days of receiving your grievance.

Urgent Grievance
If you have an urgent grievance that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), we will notify you of our decision within 72 hours.

If you are dissatisfied with our resolution of your grievance, you can contact the Department of Managed Health Care, request an Independent Medical Review (IMR) or pursue arbitration, litigation or other type of administrative proceeding. Unless you have an urgent grievance or we have not resolved your grievance within 30 days, you must complete our grievance and appeals process before you can take these actions.

If you are appealing a post-service claim decision, you must file an appeal within 180 calendar days from the time you receive the notice of the adverse decision.

For post-service claims appeals, you can appeal by sending a written appeal to the address on the notice of the adverse decision, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within the timeframe indicated above under the *Standard (Non-Urgent) Grievance* and *Urgent Grievance*.

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

Department of Managed Health Care
The California Department of Managed Health Care (Department) is responsible for regulating health care service plans. When you disagree with us, you should first follow our grievance and appeals process before contacting the Department unless you have an urgent grievance.
You can call the Department for help with a grievance or appeal involving:

- An emergency or urgent grievance
- A grievance that has not been satisfactorily resolved by us
- A grievance that has remained unsolved for more than 30 days

The Department has a toll-free telephone number 1-888-HMO-2219 and a TDD line 1-877-688-9891 for the hearing and speech impaired. The Department's Internet web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions. You can also send your complaints to:

California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Independent Medical Review

You may also be eligible for an Independent Medical Review (IMR) as explained below. The IMR process will provide an impartial review of medical decisions made by us. Independent medical review is a review managed by the California Department of Managed Health Care.

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

- We decided the service or supply is not **medically necessary**, or not appropriate (disputed health care services)
- We decided the service or supply is experimental or investigational

If our claim decision is one for which you can seek independent medical review, we will indicate that in the notice of adverse decision or determination we send you. That notice will also include the independent medical review application form. You should complete the form and send it (in the envelope provided) to the California Department of Managed Health Care. The Department will review your request and determine if you are eligible for independent medical review.

When we receive notice from the Department approving your request for an independent medical review, we will submit the documents required to the Department, you and your provider.

Your appeal will be submitted to the Independent Medical Review Organization (IMRO) for review by a medical specialist or a panel of medical specialists. Those specialists will determine whether or not the care is medically necessary. You will receive a copy of the independent medical review assessment.

The independent medical review will not cost you any money.

Independent medical review procedures for disputed health care services

You must:

- File an appeal regarding the disputed health care services
- Have participated in our grievance/appeals process for 30 days
  (If your appeal involves a request for emergency services or urgent services, you are not required to participate in our grievance/appeals process)
- Apply to the California Department of Managed Care for an independent medical review within 6 months of the date the disputed health care service has been denied, modified or delayed by us (or a network provider)

Your provider must have recommended the services or you must have received urgent or emergency care that a provider deemed medically necessary. Or, you must have been seen by a provider for the diagnosis or treatment of the medical condition. Upon request, we will expedite access to a network provider. You may request an independent medical review whether or not the provider recommends the service.

You may also request an independent medical review for services recommended or performed by an out-of-network provider. We have no liability to pay for the services of an out-of-network provider unless you have been referred according to the referral requirements, if required by the plan. See the Medical necessity, **referral** and precertification requirements section for more details.

Independent medical review procedure for experimental and investigative treatment

You can request an independent medical review when:

- You have a life-threatening or seriously debilitating illness
- Your physician certifies that you have that condition and:
  - Standard therapies have not been effective in improving your condition.

- Standard therapies would not be medically appropriate.
  There is no more beneficial standard therapy covered by the plan than what your physician is proposing.
- Your physician has certified in writing that the proposed treatment is more beneficial to you than any other standard therapy.
- You or your physician has provided us with a written statement that certifies the requested treatment is more beneficial to you than any other standard therapy. You or your physician must base this statement on two forms for medical and scientific evidence.

The chart below shows a timetable view of the independent medical review timeline.

Type of treatment	**When we notify you**	**When we send info to the DMHC**	**When the IMRO decides**
Experimental and investigative	Within 5 business days of the decision to deny coverage, in writing, of the opportunity to request the external independent review	3 days after receiving notice they approved your request 24 hours for urgent request	30 days 3 days for urgent request
Disputed healthcare services	At the end of the appeals process	3 days after receiving notice they approved your request 24 hours for urgent request	30 days 3 days for urgent request

What happens after the IMRO makes their decision?

If the IMRO determines that the care requested is **medically necessary**, or does not qualify as experimental or investigational, we will cover the services which were the subject of the appeal.

Obtaining an IMRO decision faster:

There are two scenarios when you may be able to get a faster external review:
Your **provider** tells us a delay in receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

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

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

The contract holder is responsible for paying premiums. If you are required to contribute to the premium, the contact holder will tell you the amount and how to pay it (such as payroll deduction).

When you can join the plan

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

You can enroll:

- At the end of any waiting period the contract holder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your "dependents") at this time too.
If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your civil union partner who meets any contract holder rules and requirements under state law
- Your domestic partner who meets contract holder rules and requirements under state law
- Dependent children – yours or your spouse's or partner's
    - Dependent children must be:
        - Under 26 years of age
    - Dependent children include:
        - Natural children
        - Stepchildren
        - Adopted children including those placed with you for adoption
        - Foster children
        - Children you are responsible for under a qualified medical support order or court order

Adding new dependents

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

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

- Birth
- Adoption or placement for adoption

- Marriage
- Legal guardianship
- Court or administrative order

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

Special times you can join the plan

You can enroll in these situations:

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

We must receive the completed enrollment information within 31 days after the event.

You can also enroll in these situations:

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

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

Notification of change in status

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

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

Starting coverage

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

Stopping coverage

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

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

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends

- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage
- You stop making premium contributions, if any apply
- Your coverage ends for any of the reasons listed above except:
  - Exhaustion of your overall maximum benefit.
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners or civil unions
- The date the domestic partnership or civil union ends
  - You will need to complete a Declaration of Termination of Domestic Partnership

What happens to your dependents if you die?

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

Why would we end your coverage?

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

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

We will not end your coverage because of your health status or health care needs. We also will not end your coverage because you filed an appeal. If you believe we ended your coverage because of these things, you may request a review by the Director of the California Department of Managed Health Care. See the *Grievances and Appeals* section.

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) rights

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months

after a qualifying event. The qualifying event is something that happens that results in you losing your coverage. The qualifying events are:

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

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

Continuation of coverage for other reasons

To request an extension of coverage, just contact us.

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

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

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

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

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

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

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

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

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

We will send you a notice at least 90 days before your child reaches the plan age limit. We may ask you to send us proof of the disability within 60 days of the date coverage would have ended.

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

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

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

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

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

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

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

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this EOC

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

How we administer this plan

We apply policies and procedures to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

If a service cannot be provided to you

Sometimes things happen outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund any unearned premium.

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *Grievances and Appeals section.* You cannot take any action until 60 days after we receive written submission of a claim.

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage:

- We will give you written notice, via certified mail at least 30 days prior to the effective date of any rescission of coverage. This notice will explain the reason we are rescinding your coverage.
- You have the right to an Aetna appeal.
- You have the right to a third-party review conducted by the California Department of Managed Health Care.

We will not rescind your coverage for any reason after it has been in force for 24 months.

Some other money issues

Assignment of benefits

When you direct us to pay your benefits to someone you name, that's assigning your benefits. When you see a **provider**, they will usually bill us directly. When you assign your benefits to your out-of-network provider, we will pay them directly. A direction to pay a **provider** is not an assignment of any legal rights.

Financial sanctions exclusions

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

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

Recovery of overpayments

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

When you are injured

If someone else caused you to need care – say, a careless driver who injured you in a car crash – you may have a right to get money. We are entitled to that money, based on the reasonable cost of benefits we pay for your care. We have that right no matter whom the money comes from – for example, the other driver, the contract holder, or another insurance company.

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

- Agreeing to repay us from money you receive because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

The amount of the money can be reduced if a judge, jury, or arbitrator decides you had some fault for the injury.

The amount of the money owed will not exceed one-third of the recovery, settlement, judgement or other source of compensation if you have an attorney or one-half of the recovery, settlement, judgement or other source of compensation if you did not have an attorney.

Sometimes your provider may also be entitled to that money. If your provider has been paid capitation, the lien will be limited to 80% of the usual and customary charge for the same service charged in the geographic region on a fee for service basis.

Your health information

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

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

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

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Discount arrangements

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

Third-party service providers are independent contractors. The third-party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

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

Glossary

Behavioral health provider
A **health professional** who is properly licensed or certified to provide **covered services** for mental health and **substance related disorders** in the state where the person practices. Also includes qualified autism service providers, qualified autism service professionals and qualified autism service paraprofessionals.

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

Coinsurance
A percentage paid by a covered person for a **covered service**.

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

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

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

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

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

Emergency medical condition
A severe medical condition that:

- Comes on suddenly
- Needs immediate medical care
- Leads you to reasonably believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby (including a pregnant woman in active labor)

A mental health condition is also an **emergency medical condition** when, due to a **mental disorder**, either of the following is true:

- You are an immediate danger to yourself or to others
- You are immediately unable to provide for or use food, shelter, or clothing due to the **mental disorder**

Emergency services
Treatment given in a **hospital's** emergency room. This includes evaluation of and treatment to stabilize the **emergency medical condition**.

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

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

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

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

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

- Dosage
- Safety
- Strength
- Quality
- Performance

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

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

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

Infertile, infertility

A disease defined by the failure to become pregnant:

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

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

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

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

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

Mental disorder

A **mental disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental disorder** is in the most recent edition of *The International Classification of Diseases, Tenth Edition (ICD-10)*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Residential treatment facility
An institution specifically licensed as a **residential treatment facility** by applicable laws to provide for mental health or **substance related disorder** residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

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

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

For substance related residential treatment programs:

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

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

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

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

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

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

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

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

Skilled nursing facility does not include institutions that provide only:

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

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

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

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drugs
These are **prescription** drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us to access the list of specialty drugs, including biosimilar **prescription** drugs.

Specialty pharmacy
This is a pharmacy designated by us as **a network pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

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

Step therapy
A form of **precertification** under which certain **prescription** drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** is available upon request or on our website at https://www.aetna.com/individuals-families/find-a-medication.html.

Substance related disorder

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

Surgery, surgical procedure

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

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

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Telephone calls
- Any other method required by law

Terminal illness

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

Urgent condition

An illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**.

Value prescription drugs

A group of medications determined by us that may be available at a reduced **copayment** or **coinsurance** and are noted on the **drug guide**.

Walk-in clinic

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

- Drug store
- Pharmacy

- Retail store
- Supermarket

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

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

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

The Office of Civil Rights recently issued a Non-discrimination Rule in response to Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination because of race, color, national origin, sex, age or disability in health-related insurance or other health-related coverage. This applies to Aetna. Changes to health insurance plans are effective on the first day of the policy or plan year beginning on or after January 1, 2017.

Some language changes may not be in the enclosed certificate of coverage or policy. This may be because the language is still under official review for approval. See the *Important note* below for how this affects your policy or plan.

Important note:
We will comply with the requirements of the Rule for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Below is a summary of some of the recent Non-discrimination Rule changes.

An insurer covered by the Rule that provides or administers health-related insurance or other health-related coverage:

- Shall not:
  - Cancel, limit or refuse to issue or renew a policy or plan
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a person because of race, color, national origin, sex, age, or disability.

- Shall not:
  - Deny or limit coverage
  - Deny or limit coverage of a claim
  - Apply additional cost sharing

  to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

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

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

Covered California

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

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

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

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

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

To qualify for help paying for insurance, you must:

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

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

Medi-Cal

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

- Your income is low; and
- You are a U. S. citizen, U.S. national or lawfully present in the U.S age 26 and older;
- Your income is low; and

- You are an adult age 19 through 25 who does not have satisfactory immigration status or is unable to establish satisfactory immigration status or to verify United States citizenship.

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

You can also get Medi-Cal if you are:

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

Other rules or requirements may apply.

For More Information

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

AETNA HEALTH OF CALIFORNIA INC. RIDER

Infertility treatment - comprehensive infertility

Rider effective date: January 01, 2021

This comprehensive **infertility** rider is added to your evidence of coverage (EOC). It describes your comprehensive **infertility** benefit. This rider is subject to all other requirements described in your EOC, including general exclusions and defined terms.

Coverage and exclusions

Covered services

Covered services include the following **infertility** services provided by a network **infertility specialist**:

- Ovulation induction cycle(s) while on menotropin medications
- Intrauterine/intracervical insemination

A "cycle" is an attempt at ovulation induction while on menotropin medications or any cycle that uses intrauterine/intracervical insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

How to find a network infertility specialist and facility

The first step to using your comprehensive **infertility** health care services is enrolling with our National Infertility Unit (NIU) by calling 1-800-575-5999. Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They have expertise in all areas of **infertility** and can help with enrollment, **precertification** and eligibility.

Your **network provider** will request approval from us in advance for your **infertility** services.

Who is eligible for infertility services?

You are eligible for these services if:

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

Unmedicated day 3 FSH level criteria

You have been diagnosed with **infertility** and are	Number of donor artificial insemination cycles (not paid for by plan)	You have had an unmedicated day 3 FSH test done within the past	The results of your unmedicated day 3 FSH test
A female under 35 years of age with or without a male partner	At least 12 cycles	12 months	Less than 19 mIU/mL in your most recent lab test
A female 35 years of age or older with or without a male partner	At least 6 cycles	6 months	If you are under 40, less than 19 mIU/mL in your most recent lab test If you are age 40 or older, must be less than 19 mIU/mL in all prior tests performed after age 40

Exclusions

The following are not **covered services**.

- All **infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Cryopreservation (freezing), storage or thawing of eggs, embryos, or sperm or reproductive tissue, unless due to iatrogenic **infertility**.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without **surgical** reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age-related ovarian insufficiency (e.g. perimenopause, menopause).
- Treatment for dependent children.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Schedule of benefits

This schedule of benefits lists the **deductibles**, limits and **copayments** or **coinsurance**, if any that apply to the services you receive under this rider. This rider is subject to the requirements described in your plan schedule of benefits unless otherwise noted below.

Important note
All **covered services** described in this rider are subject to the contract year **deductible**, **out-of-pocket maximum**, limits, **copayment** or **coinsurance** described in the medical plan schedule of benefits unless otherwise noted below.

Deductible, copayments, coinsurance and maximums

Outpatient services

Description	In-network
Performed at an **infertility specialist** office	$40 per visit no **deductible** applies
Performed at a **hospital** outpatient department	$40 per visit no **deductible** applies
Performed at an outpatient facility other than a **hospital** outpatient department	$40 per visit no **deductible** applies

Limits

Description	In-network
Maximum number of ovulation induction cycles while on menotropin medications lifetime	6

For this benefit, "lifetime" means covered benefits paid under this plan or another **Aetna** or **Aetna** affiliate plan, with the same contract holder

Maximum number of intrauterine/intracervical insemination cycles lifetime	6

For this benefit, "lifetime" means covered benefits paid under this plan or another **Aetna** or **Aetna** affiliate plan, with the same contract holder

AETNA HEALTH OF CALIFORNIA INC. Rider

Prescription drug plan

Rider effective date: January 01, 2021

This **prescription** drug plan rider is added to your evidence of coverage (EOC). It describes your **prescription** drug benefits. This rider is subject to all other requirements described in your EOC, including general exclusions and defined terms.

What you need to know about the prescription drug plan

Read this rider carefully so you will know:

- How to access network pharmacies
- How to get an emergency **prescription** filled
- Coverage and exclusions
- How to access your benefit
- Where your schedule of benefits fits in
- **Precertification** requirements that apply
- Utilization review
- Requesting a medical exception
- General provisions – other things you should know
- How to read your schedule of benefits

This plan doesn't cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information, see the schedule of benefits.

Prescription drug synchronization

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

Important note about filling a prescription:
A pharmacist may refuse to fill a **prescription** order or refill when, in their professional judgement, the **prescription** should not be filled.

How to access network pharmacies

How to find a network pharmacy

You can find a network pharmacy online or by phone. See the *Contact us* section for how.

You may go to any of our network pharmacies. If you don't get your **prescription** at a network pharmacy, it will not be a **covered service** under the plan.
Network pharmacies include a:

- **Retail pharmacy**
- **Mail order pharmacy**

- **Specialty pharmacy**

When the pharmacy you use leaves the network

When your pharmacy leaves the network, you will have to get your **prescriptions** at another network pharmacy. You can use your **provider** directory or call the number on your ID card to find and select another network pharmacy in your area.

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share will be
A network pharmacy	The plan cost share
Out-of-network pharmacy	The full cost of the **prescription**

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

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

Coverage and exclusions

Providing covered services

Your **prescription** drug plan provides **covered services**. For covered pharmacy services:

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

Covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for the treatment of cancer if it is recognized in a standard reference publication or recommended in the medical literature for this use. This applies even if the drug is not approved by the U.S. Food and Drug Administration (FDA) for the same use.

Contraceptives (birth control)

For females who are able to become pregnant, your **prescription** drug plan covers certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must submit the **prescription** to the pharmacy for processing. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand name prescription drug** or device at no cost share.

Preventive contraceptives important note:
You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review.

Diabetic supplies

Covered services include items such as:

- Diabetic needles, syringes and pens
- Test strips for blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See the *Diabetic services, supplies, equipment, and education* section of the certificate for more information.

Immunizations

Covered services include preventive immunizations as required by the Affordable Care Act guidelines when administered at a network pharmacy. You can call the number on your ID card to find a participating network pharmacy. You should contact the pharmacy for vaccine availability, as not all pharmacies will stock all available vaccines.

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). Eligibility for coverage is 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 symptoms(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
    - The dosage of a drug for your 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.

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

Over-the-counter drugs

Covered services include certain OTC medications, as determined by the plan. Coverage of these medications requires a **prescription**. You can access a list of these OTC medications. See the *Contact us* section for how.

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC drugs and supplements, as required by the ACA.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at:

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

Sexual dysfunction or enhancement drugs

Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement. See the *Contact us* section for how to find the most up-to-date information on dosing.

Tobacco cessation prescription and OTC drugs

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

Exclusions

The following are not **covered services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods
- Drugs or medications
    - Administered or entirely consumed at the time and place they are prescribed or provided
    - Which do not require a **prescription** by law, even if a **prescription** is written
    - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
    - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
    - That are therapeutically the same or an alternative to an OTC drug unless we have approved a medical exception
    - Not approved by the FDA or not proven safe or effective
    - Provided under your medical plan while inpatient at a healthcare facility
    - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee
    - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)

  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy, for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes.
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule or the certificate
- **Infertility**:
  - **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Insulin pumps, tubing or other ancillary equipment and supplies for insulin pumps
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment to a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addiction, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

How to access your benefit

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

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of **prescription** drugs. A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill is limited to a maximum 90 day supply.

Specialty pharmacy

We cover **specialty prescription drugs** when filled through a network **retail** or **specialty pharmacy**. Each **prescription** is limited to a maximum 30 day supply. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

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

Where your schedule of benefits fits in

You are responsible for paying your part of the cost share for **prescription** drugs covered under the plan. This schedule of benefits lists the **deductibles**, limits and **copayments** or **coinsurance**, if any, that apply to the **covered services** you receive under the **prescription** drug plan.

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

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

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

Precertification requirements that apply

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

Step therapy is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. You will find **step therapy prescription** drugs in the **drug guide**.

Call us or go online to get the most up-to-date **precertification** requirements and list of **step therapy** drugs. See the *Contact us* section for how.

The chart below shows the different types of precertification requests and how much time we have to tell you about our decision.

Type of request	Standard (non-urgent)	Exigent circumstances
Initial decision by us	72 hours	As soon as possible, but no longer than 24 hours
If we need more information, we will notify you within	Not applicable	24 hours
Once we have more information, our decision will be made	Not applicable	24 hours
How long the drug will be covered if request is approved	As long as prescribed, including refills	As long as prescribed, including refills

A request under exigent circumstances can be made when:

- Your condition may seriously affect your life, health, or ability to get back maximum function
- You are going through a current course of treatment using a **non-preferred drug**

Utilization review

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

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

Requesting a medical exception

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

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

- Contacting our **Precertification** Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to:
  - CVS Health
    ATTN: Aetna PA
    1300 E Campbell Road
    Richardson, TX 75081

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

General provisions – other things you should know

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

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

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

If a pharmacy's retail price for a **prescription** drug is less than your total cost share amount, you will not be required to pay more than the retail drug price. The amount you pay for the **prescription** drug will apply to both the **deductible**, if any, and the **maximum out-of-pocket limit** in the same manner as if you had purchased the **prescription** drug by paying your part of the cost share amount.

Partial fill dispensing for Schedule II controlled substances, such as opioids

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

How to read your schedule of benefits

How your cost share works

- The **deductibles**, **copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every **prescription** drug. You pay the full amount of any **prescription** drug you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **provider** or contact us if you have a question about what your cost share will be.

Important note:
All **covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** described in the medical plan schedule of benefits unless otherwise noted below.

How your cost share works

Your **copayment** or **coinsurance** is the amount you pay for each **prescription** fill or refill. The schedule of benefits shows you the cost share you need to pay for a specific **prescription** fill or refill. You will pay any cost share directly to the network pharmacy.

How your prescription drug maximum out-of-pocket limit works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of the year.

Plan features

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand name prescription drug** for that method will be paid at 100%.

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

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug deductible and the per **prescription** cost share will not apply to treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%.

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$3,500 per calendar year
Family	$7,000 per calendar year

General coverage provisions

This section explains the **maximum out-of-pocket limits** in this schedule.

Prescription drug maximum out-of-pocket limits provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Individual prescription drug maximum out-of-pocket limit

Once the amount of the cost share and **deductible** you and your covered dependents pay for **covered services** during the year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for that person.

Family prescription drug maximum out-of-pocket limit

After the amount of the cost share and **deductible** you and your covered dependents pay for **covered services** during the year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charges for **covered services** that apply toward the limit for the rest of the year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **prescription** drug **maximum out-of-pocket limit** is met by a combination of family members with no single person in the family contributing more than the individual **maximum out-of-pocket limit** in a year

When this happens, the individual **maximum out-of-pocket limit** is met for the rest of the year.

This plan has an individual and family **prescription** drug **maximum out-of-pocket limit**.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services**

Covered services

Preferred generic prescription drugs

Description	In-network
30 day supply at a **retail pharmacy**	$15
90 day supply at **retail pharmacy**	3 times the 30 day amount
90 day supply at **mail order pharmacy**	$15

Preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$30
90 day supply at **retail pharmacy**	3 times the 30 day amount
90 day supply at a **mail order pharmacy**	$60

Non-preferred generic prescription drugs

Description	In-network

30 day supply at **retail pharmacy**	$50
90 day supply at **retail pharmacy**	3 times the 30 day amount
90 day supply at a **mail order pharmacy**	$100

Non-preferred brand name prescription drugs

Description	In-network
30 day supply at **retail pharmacy**	$50
90 day supply at **retail pharmacy**	3 times the 30 day amount
90 day supply at a **mail order pharmacy**	$100

Specialty prescription drugs

Description	In-network
30 day supply at a **specialty pharmacy** or **retail pharmacy**	30% but no more than $150

Anti-cancer prescription drugs taken by mouth

Description	In-network
30 day supply at **retail pharmacy**	$0
90 day supply at **retail pharmacy**	$0
90 day supply at **mail order pharmacy**	$0

Contraceptives (birth control)

Brand name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
90 day supply or 12 month supply of generic and OTC drugs and devices	$0
90 day supply or 12 month supply of **brand name prescription drugs** and devices	Paid based on the tier of drug in the schedule

Diabetic supplies, drugs and insulin

Description	In-network
30 day supply at **retail pharmacy**	Paid based on the tier of drug in the schedule
90 day supply at a **retail pharmacy**	Paid based on the tier of drug in the schedule
90 day supply at **mail order pharmacy**	Paid based on the tier of drug in the schedule

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered drugs and supplements or more information see the *Contact us* section.

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer **prescription** drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered risk reducing breast cancer drugs or more information, see the *Contact us* section.

Tobacco cessation drugs

Description	In-network
Tobacco cessation **prescription** and OTC drugs	$0
Limit	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.

If you or your **provider** requests a covered **brand name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand name drug, plus the cost share that applies to the brand name drug. The cost difference does not apply toward your **prescription** drug **maximum out-of-pocket limit**.

Aetna Health of California Inc.
HMO

Schedule of benefits

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

Prepared exclusively for:
Contract holder: NIAGARA BOTTLING LLC
Contract holder number: 0803918
HMO group agreement effective date: January 01, 2021
Plan effective date: January 01, 2021

Schedule of benefits

This schedule of benefits lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles**, **copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles**, **copayments** and **coinsurance** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/.

Important note:
Covered services are subject to the calendar year **deductible**, **maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits.

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **coinsurance** you pay when you get **covered services** from a network **provider**. This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from the **PCP** you select. You will pay a higher cost share when you get **covered services** from a **PCP** that is not your **PCP**. If you did not select a **PCP**, you will pay a higher cost share for **covered services** from any **PCP**, network **physician** or **specialist**.

How your maximum out-of-pocket works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your EOC.

Aetna Health of California Inc.'s HMO group agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your EOC.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network
Individual	$1,500 per calendar year
Family	$3,000 per calendar year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	$3,500 per calendar year
Family	$7,000 per calendar year

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **coinsurance**, if any, for these **covered services**.

Individual deductible

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

Family deductible

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

Deductible credit

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

Copayment

This is a dollar amount or percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Coinsurance

This is a percentage you pay for a **covered service**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit provisions

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** may include those provided under the medical plan and the outpatient **prescription** drug plan.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.

- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the EOC and the SOB

Your financial responsibility and decisions regarding benefits

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

Covered services

Acupuncture

Description	In-network
Acupuncture	$15 per visit
	no **deductible** applies
Visit limit per year	20

Ambulance services

Description	In-network
Emergency services	$100 per trip
	no **deductible** applies
Non-emergency services	Not covered

Clinical trials

Description	In-network
Experimental or investigational therapies	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received

Diabetic services, supplies, equipment, and education

Description	In-network
Diabetic services	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received
Diabetic education	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	50% per item
	after **deductible**

Emergency services

Description	In-network
Emergency room	$150 per visit
	after **deductible**
Complex imaging, lab and radiology services	No charge

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

Foot orthotic devices

Description	In-network
Orthotic devices	$0 per item
	no **deductible** applies

Gender reassignment

Description	In-network
Performed at inpatient hospital	10% per admission
	after **deductible**
Performed in a **hospital** outpatient facility	10% per visit after **deductible**
Performed in a facility other than a **hospital** outpatient facility	10% per visit after **deductible**

Habilitation therapy services

Physical, occupational therapies

Description	In-network
PT, OT therapies	$40 per visit
	no **deductible** applies

Speech therapy

Description	In-network
Speech therapy	$40 per visit

	no **deductible** applies

Hearing aids

Description	In-network
Hearing aids	$40 per visit

Limit per 24 months	$1,500

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	$0 per visit after **deductible**

Visit limit per day	3 intermittent visits
Limit per year	120

Hospice care

Description	In-network
Inpatient services - **room and board**	10% per admission

	after **deductible**

Day limit per year	unlimited days
Limit per year	unlimited
Limit per lifetime	unlimited

Outpatient services	$0 per visit

	after **deductible**

Visit limit per year	unlimited
Limit per year	unlimited
Limit per lifetime	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8-12 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8-12 hours a day.

Hospital care

Description	In-network
Inpatient services – **room and board**	10% per admission

	after **deductible**

Other inpatient services	No charge

Infertility services

Description	In-network
Treatment of basic **infertility**	Covered based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	$40 per visit

	no **deductible** applies

Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – **room and board**	10% per admission

	after **deductible**

Other inpatient services	No charge

Services performed in **physician** or **specialist** office or a facility	$25 per visit

	no **deductible** applies

Other services and supplies	Covered based on type of service and where it is received

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

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-**room and board** including **residential treatment facility**	10% per admission

	after **deductible**

Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** consultation	$40 per visit
	no **deductible** applies
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** cognitive behavioral therapy consultations	$0 per visit no **deductible** applies
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	$0 per visit
	no **deductible** applies

Nutritional support

Description	In-network
Nutritional support	$0 per item
	after **deductible**

Obesity (bariatric) surgery

Description	In-network
Obesity (bariatric) surgery	Covered based on type of service and where it is received

Outpatient surgery

Description	In-network
At **hospital** outpatient department	10% per visit after **deductible**
At facility that is not a **hospital**	10% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received

Physician and specialist services

Including surgical services

Your PCP

Description	In-network
Physician office hours (not surgical, not preventive)	$25 per visit
	no **deductible** applies
Immunizations that are not considered preventive care	Covered based on type of service and where it is received.
Physician home visit (not preventive)	$25 per visit
	no **deductible** applies
Physician surgical services	$25 per visit
	no **deductible** applies
Physician telemedicine consultation	$25 per visit
	no **deductible** applies

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	$40 per visit
	no **deductible** applies
Specialist home visit (not preventive)	$40 per visit
	no **deductible** applies
Specialist surgical services	$40 per visit
	no **deductible** applies
Specialist telemedicine consultation	$40 per visit
	no **deductible** applies

Preventive care

Description	In-network
Preventive care services	$0 no **deductible** applies
Breast feeding counseling and support	$0 no **deductible** applies
Breast feeding counseling and support limit per year	• 6 visits in a group or individual setting • Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies	$0 no **deductible** applies
Breast pump, accessories and supplies limit	• Electric pump: 1 every 3 years • Manual pump: 1 per pregnancy • Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse, obesity, healthy diet, sexually transmitted infection, tobacco cessation	$0 no **deductible** applies
Counseling for alcohol or drug misuse visit limit per day	1
Counseling for alcohol or drug misuse visit limit per year	5 visits/12 months
Counseling for obesity, healthy diet visit limit per day	1

Counseling for obesity, healthy diet visit limit per year	• 26 visits/12 months • Of the total visits allowed per year, 10 may be used for high cholesterol and other known risk factors for heart disease and diet-related chronic diseases
Counseling for sexually transmitted infection visit limit per year	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit per year	8 visits/12 months
Family planning services (female contraceptive counseling)	$0 no **deductible** applies
Family planning services (female contraceptive counseling) limit per year	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	$0 no **deductible** applies
Immunizations limit	• Covered persons age 0-99 • Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention • For details, contact your **physician**
Preventive care contraceptives (birth control)	$0 no **deductible** applies
Preventive care drugs and supplements	$0 no **deductible** applies
Preventive care drugs and supplements limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the U.S. Preventive Services Task Force (USPSTF) • For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	$0 no **deductible** applies
Preventive care risk reducing breast cancer **prescription** drugs limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF • For a current list of covered risk reducing breast cancer drugs or more information, see the *Contact us* section
Preventive care tobacco cessation **prescription** and OTC drugs	$0 no **deductible** applies

Preventive care tobacco cessation **prescription** and OTC drugs limit	• Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF • For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section • A visit is equal to a session of up to 15 minutes
Routine cancer screenings	$0 no **deductible** applies
Routine cancer screening limits	• Subject to any age, family history and frequency guidelines as set forth in the most current: – Evidence-based items that have a rating of A or B in the current recommendations of the (USPSTF) – The comprehensive guidelines supported by the Health Resources and Services Administration • For more information contact your **physician** or see the *Contact us* section of your EOC
Routine lung cancer screening limit	• 1 screenings every 12 months • Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	$0 no **deductible** applies
Routine physical exam limits	• Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents • Limited to 7 exams from age 0-12 months, 3 exams age 1-2, 3 exams age 2-3 and 1 exam every 12 months after that age, up to age 22, 1 exam every 12 months after age 22 • High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months
Well woman routine GYN exam	$0 no **deductible** applies
Well woman preventive care visits limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	In-network
Prosthetic devices	$0 per item

	no **deductible** applies

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Covered based on type of service and where it is received

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	$40 per visit no **deductible** applies

Pulmonary rehabilitation

Description	In-network
Pulmonary	$40 per visit no **deductible** applies

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Covered based on type of service and where it is received

Physical and occupational therapies

Description	In-network
PT and OT	$40 per visit
	no **deductible** applies

Speech therapy

Description	In-network
Speech therapy	$40 per visit
	no **deductible** applies

Spinal manipulation

Description	In-network
Spinal manipulation	$15 per visit
	no **deductible** applies
Visit limit per day	1
Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services – **room and board**	10% per admission

	after **deductible**

Day limit per year	100

Other inpatient services and supplies	No charge

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	In-network
Inpatient services – **room and board** during a **hospital stay**	10% per admission
	after **deductible**
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** consultation	$40 per visit
	no **deductible** applies
Outpatient office visit to a **physician** or **behavioral health provider** Includes **telemedicine** cognitive behavioral therapy consultations	$0 per visit no **deductible** applies
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	$0 per visit
	no **deductible** applies

Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a **hospital**	$100 per visit no **deductible** applies
At **hospital** outpatient department	$100 per visit no **deductible** applies

Diagnostic lab work

Description	In-network
At facility that is not a **hospital**	$0 per visit no **deductible** applies
At **hospital** outpatient department	$0 per visit no **deductible** applies

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a **hospital**	$0 per visit no **deductible** applies
At **hospital** outpatient department	$0 per visit no **deductible** applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network
In **physician** office	Covered based on type of service and where it is received
At an infusion location	Covered based on type of service and where it is received
In the home	Covered based on type of service and where it is received
At **hospital** outpatient department	Covered based on type of service and where it is received
At facility that is not a **hospital**	Covered based on type of service and where it is received

Radiation therapy

Description	In-network
Radiation therapy	Covered based on type of service and where it is received

Transplant services

Description	Network (IOE facility)	Network (non-IOE facility)
Inpatient services and supplies	10% per admission	Not covered

	after **deductible**	Not covered

Other inpatient services and supplies	No charge	Not covered

Outpatient services performed at **hospital** outpatient department	See Inpatient services, above	Not covered
Outpatient services performed at facility other than **hospital** outpatient department	See Inpatient services, above	Not covered

Physician services	See Inpatient services, above	Not covered

Limit per lifetime	Unlimited	Not covered

Transplant important note:
See the *Transplant services* benefit in the *Coverage and exclusions* section of the EOC for more information. The limit applies to all transplant services received while you are a member of an Aetna plan or one associated with Aetna. The plan **lifetime maximum**, if any, will not apply to transplant services. The transplant limit will apply.

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

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

Description	In-network
Urgent care facility	$25 per visit
	no **deductible** applies
Complex imaging, lab and radiology services	No charge
Non-urgent use of an urgent care facility or **provider**	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network
Adult vision exam	$0 per visit
	no **deductible** applies
Limit	Limited to covered persons age 19 and older
Visit limit	1 visit(s) every 24 months

Pediatric vision care

Description	In-network
Pediatric vision exam	$0 per visit
	no **deductible** applies
Limit	Limited to covered persons through the end of the month in which the person turns 19
Visit limit	1 visit(s) every 24 months

Walk-in clinic

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

Description	In-network
Non-emergency services	$25 per visit
	no **deductible** applies
Preventive immunizations	$0 per visit no **deductible** applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician**
Screening and counseling services	$0 per visit no **deductible** applies
Screening and counseling limits	See the *Preventive care services* section of the SOB