Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-596-4015.

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

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

Texas Health Aetna provides 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 1-800-596-4015.

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
1-800-648-7817, TTY: 711
Fax: 859-425-3379
Email: 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).

Texas Health Aetna is the brand name used for products and services provided by Texas Health + Aetna Health Insurance Company and Texas Health + Aetna Health Plan Inc. Texas Health Aetna is an affiliate of Texas Health Resources and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Texas Health Aetna.

Language Assistance Taglines here

TTY: 711

For language assistance in English call 1-800-596-4015 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 800-596-4015. (Spanish)

欲取得繁體中文語言協助，請撥打800-596-4015 ，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 800-596-4015 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 800-596-4015 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 800-596-4015 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 800-596-4015. (Arabic)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 800-596-4015 પર કૉલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 800-596-4015 पर मुफ्त कॉल करें।

日本語で援助をご希望の方は、800-596-4015 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인800-596-4015 번으로 전화해 주십시오. (Korean)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 800-596-4015 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

برای راهنمایی به زبان فارسی با شماره 800-596-4015 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 800-596-4015 . (Russian)

اُردو میں لسانی معاونت کے لیے 800-596-4015 . پر مفت کال کریں۔(Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 800-596-4015. (Vietnamese)

Texas Health + Aetna Health Plan Inc.
612 East Lamar Boulevard, Suite 100, Arlington, TX 76011
1-800-MY-Health (694-2358)
www.texashealthaetna.com

Health Maintenance Organization (HMO) Evidence of Coverage (EOC)

Plan name:	**TX THA CP Silver HMO 50%**
PPID:	**TXN1030010118871**

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

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

Underwritten by Texas Health + Aetna Health Plan Inc. in the state of Texas

Welcome

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

This is your Evidence of Coverage, or EOC for short. It is one of three documents that together describe the benefits covered by your **Texas Health + Aetna Health** plan for coverage.

This EOC will tell you about your **covered benefits** – what they are and how you get them. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the group agreement between **Texas Health + Aetna Health Inc.** (**Texas Health + Aetna Health**) and your **contract holder**. Ask your employer if you have any questions about the group agreement.

Sometimes, these documents have amendments, inserts or riders which we will send you. These change or add to the documents they're part of. When you receive these, they are considered part of your **Texas Health + Aetna Health** plan for coverage.

Where to next? Try the *Let's get started!* section. *Let's get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Texas Health + Aetna Health** plan.

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Let's get started!

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

Some notes on how we use words

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

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

What your plan does – providing covered benefits

Your plan provides **covered benefits**. Benefits are provided for **eligible health services**. Your plan has an obligation to pay for **eligible health services**.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section. Coverage is not provided for any services received before coverage starts or after coverage ends.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

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

How your plan works while you are covered

Your coverage:

- Helps you get and pay for a lot of – but not all – health care services. Benefits are provided for **eligible health services**.
- Generally will pay only when you get care from **network providers**.

1. **Eligible health services**

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

   So what are **eligible health services**? They are health care services that meet these three requirements:

   - They appear in the *Eligible health services under your plan* section.

- They are not listed in the *What your plan doesn't cover – eligible health service exceptions and exclusions* section. (We will refer to this section as the "*Exceptions*" section in the rest of this EOC.)
- They are not beyond any limits in the schedule of benefits.

2. **Providers**
   Our network of doctors, **hospitals** and other health care **providers** 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 into your secure member website at www.texashealthaetna.com

   You choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You may also go directly to a network OB, GYN or OB/GYN for **eligible health services**.

   Until a **PCP** is selected, benefits will be limited to coverage for **emergency services** and **urgent conditions**.

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

3. **Service area**
   Your plan generally pays for **eligible health services** only within a specific geographic area, called a **service area**. See *Appendix A – Service area map* for a **service area** map and a detailed list of counties within the **service area**. There are some exceptions, such as for **emergency services** and urgent care. See the *Who provides the care* section.

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

Important note for other dependents outside the service area:
If you have a dependent outside of the **service area**, their coverage outside of the **service area** will be limited to emergency and **urgent conditions** for both medical and **pharmacy** services.

4. **Paying for eligible health services– the general requirements**
   There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:
   - The **eligible health service** is **medically necessary**.
   - You get your care from:
     - Your **PCP**.
     - Another **network provider** after you get a **referral** from your **PCP**.
   - You or your **provider preauthorizes** the **eligible health service** when required.

You will find details on **medical necessity**, **referral** and **preauthorization** requirements in the *Medical necessity, referral and preauthorization requirements* section. You will find the requirement to use a **network provider** and any exceptions in the *Who provides the care* section.

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

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

6. **Disagreements**
   We know that people sometimes see things differently.

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

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

How to contact us for help

We are here to answer your questions. You can contact us by:

- Logging on to your secure member website at www.texashealthaetna.com.
- Online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

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

Your member ID card

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

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

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

Who the plan covers

You will find information in this section about:

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

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

When you can join the plan
As an employee you can enroll:

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

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

Who can be on your plan (who can be your dependent)
If you choose a plan that includes coverage for dependents, you can enroll the following family members on your plan. (They are your "dependents".)

- Your legal spouse
- Your domestic partner, who meets the rules set by your employer and requirements under state law
- Your dependent children – your own or those of your spouse domestic partner
  The children must be under 26 years of age and they include your:
  - Biological children
  - Stepchildren
  - Legally adopted children*, including any children placed with you for adoption
  - Foster children
  - Children you are responsible for under a qualified medical or dental support order or court-order (whether or not the child resides with you and whether or not the child resides inside the **service area**)
  - Grandchildren in your court-ordered custody
  - A grandchild who is your dependent for federal tax purposes
  - Any other child with whom you have a parent-child relationship

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

Effective date of coverage
Your coverage will begin after we have received your completed enrollment form. Depending on when you enroll, the start date will be either:
- On the date the **contract holder** tells us
- As described under *Special times you can join the plan* (later in this section)

Dependent coverage will start:
- On your effective date, if you enrolled them at that time.
- Generally, the first day of the month based on when we receive your completed enrollment form, if you enrolled them at another time. See *Adding new dependents* and *Special times you can join the plan* for more information.

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

You can't have coverage as an employee and a dependent and you can't be covered as a dependent of more than one employee on the plan.

Adding new dependents
If you choose a plan that includes coverage for dependents, you can add the following new dependents to your plan:
- A spouse - If you marry, you can put your spouse on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your employer when benefits for your spouse will begin:
    - If we receive your completed enrollment information by the 15th of the month, coverage will be effective no later than the first day of the following month.
    - If we receive your completed enrollment information between the 16th and the last day of the month, coverage will be effective no later than the first day of the second month.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your plan. See *Who can be on your plan (Who can be your dependent)* section for more information.
  - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your employer.
  - Ask your employer when benefits for your domestic partner will begin. It will be on the date your Declaration of Domestic Partnership is filed or the first day of the month following the qualifying event date.
- A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information. Or, you can call to notify us. You must provide the information within 31 days of birth.

  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- An adopted child - You may put an adopted child on your plan when you become a party in a suit for adoption, the adoption is complete or the date the child is placed for adoption. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.
  - You must complete your enrollment information and send it to us within 31 days after you become a party in a suit for adoption, the adoption is complete, the adoption or the date the child was placed for adoption.
  - Ask your employer when benefits for your adopted child will begin. It is usually the date of the adoption (or placement) or the first day of the month following adoption (or placement).
- A foster child – You may put a foster child on your plan when you have obtained legal responsibility as a foster parent. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents.
  - You must complete your enrollment information and send it to us within 31 days after the date the child is placed with you.
  - Ask your employer when benefits for your foster child will begin. It is usually the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your spouse domestic partner on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of your marriage declaration of domestic partnership with your stepchild’s parent.
  - Ask your employer when benefits for your stepchild will begin. It is the date of your marriage declaration of domestic partnership or the first day of the month following the qualifying event date.
- Court order – You can put a child you are responsible for under a qualified medical or dental support order or court order on your plan.
  - You must complete your enrollment information and send it to us within 31 days after the date of the court order.
  - Ask your employer when benefits for the child will begin. It is usually the date of the court order or the first day of the month following the qualifying event date.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in Medicare or any other health plan

Special times you can join the plan

Federal law allows you and your dependents, if you choose a plan that includes coverage for dependents, to enroll at times other than your employer's annual open enrollment period. This is called a special or limited enrollment period.

You can enroll in these situations when:

- You have lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- You or your dependent's enrollment or non-enrollment in a plan through the Health Insurance Marketplace was not intended, by accident or a mistake, and is because of an error, false information or delay by the marketplace.
- You or your dependent have proven to the marketplace that their plan did not honor or maintain an important provision of its contract with you
- You or your dependent qualify for access to new plans because you have moved to a new permanent location.
- You or your dependent did not enroll in this plan before because:
    - You were covered by another health plan, and now that other coverage has ended.
    - You had COBRA, and now that other coverage has ended .
- A court orders you to cover a current spousedomestic partner or a child on your health plan.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You or your dependent become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.

We must receive your completed enrollment information from you within 31 days of the event or the date on which you no longer have the other coverage mentioned above. However, the completed enrollment form may be submitted within 60 days of the event when:

- You lose your eligibility for enrollment in Medicaid or an S-CHIP plan Medicaid
- You become eligible for State **premium** assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan

Effective date of coverage

Your coverage will be in effect based on when we receive your completed enrollment application:

- No later than the first day of the following month if completed enrollment information is received by the 15th of the month
- No later than the first day of the second month if completed enrollment information is received between the 16th and the last day of the month
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

Medical necessity, referral and preauthorization requirements

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

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

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

This section addresses the **medical necessity**, **referral** and **preauthorization** requirements. You will find the requirement to use a **network provider** and any exceptions to this in the *Who provides the care* section.

Medically necessary; medical necessity

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

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

Referrals

You need a **referral** from your **PCP** for most **eligible health services**. If you do not have a **referral** when required, we won't pay the **provider**. You will have to pay for services if your **PCP** fails to ask us for the **referral**. Refer to the *What the plan pays and what you pay* section.

Preauthorization

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

Your **physician** or **PCP** is responsible for obtaining any necessary **preauthorization** before you get the care. For **preauthorization** of outpatient **prescription drugs**, see *Eligible health services under your plan – Outpatient prescription drugs – What preauthorization requirements apply*. If your **physician** or **PCP** doesn't get a required **preauthorization**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** or **PCP** fails to ask us for **preauthorization**. If your **physician** or **PCP** requests **preauthorization** and we refuse it, you can still get the care but the plan won't pay for it. You have the right to appeal this decision. See the *When you disagree – claim decisions and appeal procedures* section.

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

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**. If you have questions about this section, see the *How to contact us for help* section.

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

For example:

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

You can find out about exclusions in the *Exceptions* section and about limitations in the schedule of benefits.

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

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

1. Preventive care and wellness

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

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
    - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
    - United States Preventive Services Task Force
    - Health Resources and Services Administration
    - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

2. Diagnostic testing for the treatment or diagnosis of a medical condition is not covered under the preventive care benefit. You will pay the cost sharing specific to **eligible health services** for diagnostic testing.

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

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or see the *How to contact us for help* section. This information can also be found at the www.healthcare.gov website.

Routine physical exams

Eligible health services include office visits to your **physician**, **PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam.

A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury.**

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

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

Routine physical exams for women	
• Anemia screening on a routine basis for pregnant women • Bacteriuria urinary tract or other infection screening for pregnant women • BRCA counseling about genetic testing for women at higher risk • Breast cancer mammography screenings • Breast cancer chemoprevention counseling for women at higher risk • Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women • Cervical cancer screening for sexually active women • Pap smear; or screening using liquid-based cytology methods, either alone or in conjunction with a test approved by the United States Food and Drug Administration • 1 gynecological exam every 12 months (this includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer) • Chlamydia infection screening for younger women and other women at higher risk • Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs (see the contraception sections, below for more detail) • Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test • Domestic and interpersonal violence screening and counseling for all women	• Folic acid supplements for women who may become pregnant • Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes • Gonorrhea screening for all women at higher risk • Hepatitis B screening for pregnant women at their first prenatal visit • Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women • Human Papillomavirus (HPV) DNA test: high risk HPV DNA testing) • Osteoporosis screening • Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk • Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users • Sexually transmitted infections counseling for sexually active women • Syphilis screening for all pregnant women or other women at increased risk • Well-woman visits to obtain recommended preventive services

Eligible health services also 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.

- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

Preventive care immunizations

Eligible health services include immunizations provided by your **physician** for infectious diseases.

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

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

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **physician**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling

- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

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

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco
- **Sexually transmitted infection counseling**
  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

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

These benefits will be subject to any age, family history and frequency guidelines that are:

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

- Mandated by state law

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

Prenatal care

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

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

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

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of either:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every 36 months.
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous 36 month period, the purchase of another electric breast pump will not be covered until one of these things happens:

- A 36 month period has elapsed since the last purchase
- The initial electric breast pump is broken and no longer covered under a warranty

Breast pump supplies and accessories

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

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

Family planning services –contraceptives counseling, devices and voluntary sterilization

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

Eligible health services include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:
- *Family planning services – other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs - preventive contraceptives*
- *Treatment of basic infertility*

2. Physicians and other health professionals

Physician services

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

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

Important note: All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** or **telehealth** instead. See the schedule of benefits for more information.

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician office visits

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
    - In weight reduction due to obesity and/or healthy diet
    - To stop the use of tobacco products

3. Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- General nursing care.
- Private duty nursing.
- Administration of blood and blood derivatives including the cost of the blood or blood product (e.g. blood plasma and blood plasma expanders) that is not replaced by you or for you.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Anesthesia, oxygen and oxygen therapy.
- Inhalation therapy.
- Radiological services, laboratory testing and diagnostic services.
- Meals and special diets.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery

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

Eligible health services also include the following oral **surgery** services:

- Removal of tumors, cysts, all malignant and premalignant lesions and growths of the jaws, cheeks, lips, tongue, roof and floor of the mouth
- Incision and drainage of facial abscess
- **Surgical procedures** involving salivary glands and ducts and non-dental related procedures of the accessory sinuses
- Removal of complete bony impacted teeth

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

Dental care services and anesthesia in a hospital or surgery center

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

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

Home health care

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

- Your **physician** orders them.
- The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home.
- The services are 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, respiratory or occupational therapy.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

Short-term physical, speech and occupational therapy services provided in the home are subject to the same conditions and limitations as therapy provided outside the home. See the *Short-term rehabilitation services* and *Habilitation therapy services* sections and the schedule of benefits.

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

Hospice care

Eligible health services include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

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

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

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

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

Skilled nursing facility

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

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

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

For your **stay** in a **skilled nursing facility** to be eligible for coverage, the following conditions must be met:

- The **skilled nursing facility** admission will take the place of:
  - An admission to a **hospital** or sub-acute facility.
  - A continued **stay** in a **hospital** or sub-acute facility.
- There is a reasonable expectation that your condition will improve enough to go home within a reasonable amount of time.
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis.

Important Note:
Even if you receive **eligible health services** at a health care facility that is a **network provider**, not all services may be in network. Other services you receive may be from a **physician** or facility that is an **out-of-network provider**. **Providers** that may not be **network providers** include anesthesiologists, radiologists, pathologists, neonatologists, emergency room physicians and assistant surgeons. You may receive a bill for services from these **out-of-network providers**, as we paid them at our usual and customary rate or at an agreed rate. We will work with the **providers** so that all you pay is your appropriate network level **copayments.**

4. Emergency services and urgent care

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

The types of services that are eligible for coverage include:

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

As always, you can get **emergency services** from **network providers**. However, you can also get **emergency services** from **out-of-network providers**.

If you get care from an **out-of-network provider** for an **emergency medical condition** or **urgent condition**, we will pay the **provider** at our usual and customary charge or at an agreed rate. You can contact Member Services at the toll-free number on your ID card if you receive a bill from the **out-of-network provider**. We will work with the **provider** so that all you pay is the appropriate network level **copayment**.

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

Follow-up care must be provided by your **physician**, **PCP**. Follow-up care from a **physician** other than your **PCP**, like a **specialist**, may require a **referral**. See the *Medical necessity, referral and preauthorization requirements* section for more information.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and **ambulance** assistance. If possible, call your **physician**, but only if a delay will not harm your health.

Non-emergency condition

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

In case of an urgent condition

Urgent condition within the service area

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

Urgent condition outside the service area

You are covered for urgent care obtained from a facility outside of the **service area** if you are temporarily absent from the **service area** and getting the health care service cannot be delayed until you return to the **service area**.

Non-urgent care

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

5. Pediatric dental care

Eligible health services include dental services and supplies provided by a **dental provider**. The **eligible health services** are those listed in the pediatric dental care section of the schedule of benefits. We have grouped them as Type A, B and C, and orthodontic treatment services in the schedule of benefits.

Eligible health services also include dental services provided for a dental emergency. Services and supplies provided for a dental emergency will be covered even if services and supplies are provided by an **out-of-network provider**.

A dental emergency is any dental condition which:

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

The plan pays a benefit up to the dental emergency maximum shown in the schedule of benefits.

If you have a dental emergency, you may get treatment from any dentist. You should consider calling your network **dental provider** who may be more familiar with your dental needs. If you cannot reach your network **dental provider** or are away from home, you may get treatment from any dentist. You may also call the toll-free number on your ID card for help in finding a dentist. The care received from an **out-of-network provider** must be for the temporary relief of the dental emergency until you can be seen by your **dental provider**. Services given for other than the temporary relief of the dental emergency by an **out-of-network provider** can cost you more. To get the maximum level of benefits, services should be provided by your network **dental provider**.

What rules and limits apply to dental care?

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

When does your plan cover orthodontic treatment?

Orthodontic treatment is covered for a severe, dysfunctional, disabling condition such as:

- Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement
- The following craniofacial anomalies:
  - Hemifacial microsomia
  - Craniosynostosis syndromes
  - Cleidocranial dental dysplasia
  - Arthrogryposis
  - Marfan syndrome
- Anomalies of facial bones and/or oral structures
- Facial trauma resulting in functional difficulties

If you suffer from one of these conditions, the orthodontic services that are eligible for coverage include:

- Pre-orthodontic treatment visit
- Comprehensive orthodontic treatment
- Orthodontic retention (removal of appliances, construction and placement of retainers(s))

When does your plan cover replacements?

The plan's "replacement rule" applies to:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

The "replacement rule" means that replacements of, or additions to, these dental services are covered only when:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay, onlay and veneer, complete denture, removable partial denture, fixed partial denture (bridge) or other prosthetic service was installed at least 5 years before its replacement and cannot be fixed.
- You had a tooth (or teeth) extracted. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

When does your plan cover missing teeth that are not replaced?

The installation of complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years.

Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

An advance claim review

The advance claim review gives you an idea of what we might pay for services before you receive them. Knowing this ahead of time can help you and your **dental provider** make informed decisions about the care you are considering.

When we do the advance claim review, we will look at other procedures, services or courses of dental treatment for your dental condition.

You do not have to get an advance claim review. It's voluntary. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

Important note:
The advance claim review is not a guarantee of coverage or payment. It is an estimate.

When to get an advance claim review

We recommend an advance claim review when a course of dental treatment is likely to cost more than $350. Here are the steps to get an advance claim review:

1. Ask your **dental provider** to write down a full description of the treatment you need. To do this, they must use an **Texas Health + Aetna Health** claim form or an American Dental Association (ADA) approved claim form.
2. Your **dental provider** should send the form to us before treating you.
3. We may request supporting images and other dental records.
4. Once we have received all the information we need, we will review your **dental provider's** plan. We will give you and your **dental provider** a statement of the benefits payable.
5. You and your **dental provider** can then decide how to proceed.

What is a course of dental treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dental providers** to treat a dental condition. The dental condition is diagnosed by your **dental provider** after they have examined you. A course of treatment begins on the date your **dental provider** starts to correct or treat the dental condition.

6. Specific conditions

Autism spectrum disorder

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

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.
We will cover certain early intensive behavioral interventions such as applied behavior analysis.
Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior
- That are responsible for observable improvements in behavior

Important note:
Applied behavior analysis requires **preauthorization** by **Texas Health + Aetna Health**. The **network provider** is responsible for obtaining **preauthorization**.

Diabetic equipment, supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips – blood glucose, ketone and urine
  - Injection aids for the blind
  - 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

This coverage is for the treatment of insulin dependent (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy. See the *Outpatient prescription drugs* section for diabetic supplies that you can get at a **pharmacy**.

Family planning services – other

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

- Voluntary sterilization for males
- Abortion

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

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

Maternity and related newborn care
Eligible health services include prenatal and postpartum care and obstetrical services, including care and services for complications of pregnancy. After your child is born, **eligible health services** include:

- A minimum of 48 hours of inpatient care in a health care facility **l** after a vaginal delivery
- A minimum of 96 hours of inpatient care in a health care facility **l** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

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

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

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

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

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

Mental health treatment
Eligible health services include the treatment of **mental disorders** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility**, **physician** or **behavioral health provider** as follows:

- **Inpatient room and board** at the **semi-private room rate** (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 provided during your **stay** in a **hospital**, **psychiatric hospital, crisis stabilization unit** 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** or **telehealth** consultation)
    - Other outpatient mental health treatment such as:
        - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**

    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
        - Your **physician** orders them
        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or 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)
    - Mental health injectables
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation

Substance related disorders treatment

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

- **Inpatient room and board** at the **semi-private room rate** (Your plan will cover the extra expense of a private room when appropriate because of your medical condition) and other services and supplies provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

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

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker or licensed professional counselor (includes **telemedicine** consultation)
    - Other outpatient **substance abuse** treatment such as:
        - Outpatient detoxification
        - **Partial hospitalization treatment** provided in a facility or program for **substance abuse** treatment provided under the direction of a **physician**
        - **Intensive outpatient program** provided in a facility or program for **substance abuse** treatment provided under the direction of a **physician**
        - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
        - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
            - Your **physician** orders them

        - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
        - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Treatment of withdrawal symptoms
    - Substance use disorder injectables
    - 23 hour observation

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive **surgery** 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 even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema, and prostheses.
- **Surgery** to fix teeth injured due to an accident, except as a result of chewing or biting, is covered when:
    - Teeth are sound natural teeth. This means the teeth were stable, functional and free from decay or disease at the time of the **injury**.
    - The **surgery** returns the injured teeth to how they functioned before the accident. Your **surgery** is needed to improve a significant functional impairment of a body part.
- Your **surgery** corrects a gross anatomical defect, including a congenital dental defect, present at birth or appearing after birth (but not the result of an **illness** or **injury**). The **surgery** will be covered if:
    - The defect results in severe facial disfigurement or major functional impairment of a body part.
    - The purpose of the **surgery** is to improve function.

Transplant services

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

Network of transplant specialist facilities

The amount you will pay for covered transplant services is based upon where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need

The National Medical Excellence Program® will coordinate all solid organ and bone marrow transplants and other specialized care you need.

Treatment of infertility

Basic infertility

Eligible health 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.

7. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Eligible health services include diagnostic lab services, and pathology and other tests, but only when you get them from a licensed lab.

Diagnostic radiological services

Eligible health services include radiological services (other than diagnostic complex imaging) but only when you get them from a licensed radiological facility.

Cardiovascular disease

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

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

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

- Computed tomography (CT) scanning
- Ultrasonography

Diagnostic follow-up care related to newborn hearing screening

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

Outpatient therapies

Chemotherapy

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

Outpatient infusion therapy

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

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

See the *How to contact us for help* section to learn how you can access the list of preferred infusion locations.

Infusion therapy is the administration of prescribed medications or solutions through an IV.

Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

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

Outpatient radiation therapy (therapeutic radiology)

Eligible health services include, but are not limited to, the following radiology services provided by a **health professional**:

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

Specialty prescription drugs

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

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

You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

Certain infused medications may be covered under the outpatient **prescription drug** section. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section to determine if coverage is under the outpatient **prescription drug** section or this section.

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

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it's:

- Performed at a **hospital**, **skilled nursing facility**, or **physician's** office
- Used to treat reversible pulmonary disease states
- Part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. **Eligible health services** include short-term rehabilitation services your **physician** prescribes. The services have to be performed by a:

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

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

Outpatient cognitive rehabilitation, physical, occupational and speech therapy

Eligible health services include:

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

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**.
  - Relearn skills so you can significantly regain your ability to perform the activities of daily living on your own.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness**, **injury** or **surgical procedure**.
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy.
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Inpatient and outpatient treatment for acquired brain injury

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

- Physical function
- Sensory processing
- Cognition
- Psychosocial behavior

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

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

Eligible health services include the following therapies related to an acquired brain injury:

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

Spinal manipulation

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

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

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function
- Speech therapy (except for services provided in an educational or training setting or to teach sign language), provided the therapy is expected to develop speech function as a result of delayed development

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

8. Other services

Acupuncture

Eligible health 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**.

Alzheimer's disease

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

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

Ambulance service

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

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another **hospital**, if the first **hospital** cannot provide the **emergency services** needed
- From **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
- 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 **medically necessary** treatment

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

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

Clinical trial therapies (experimental or investigational)

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

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

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

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial is approved by an Institutional Review Board that will oversee the investigation.

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

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

Durable medical equipment (DME)

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

When we **preauthorize** it, we cover the instruction and appropriate services needed for a member to learn how to properly use the item.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.

- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *Exceptions* section.

All maintenance and repairs that result from misuse or abuse are your responsibility.

Hearing aids

Eligible health services include prescribed hearing aids and hearing aid services as described below:

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments or accessories

Hearing aid services are:

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

Cochlear implants and related services

Eligible health services include cochlear implants and the following related services and supplies:

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

Nutritional supports

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

For purposes of this benefit, “low protein modified food product” means foods 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.

For coverage of drugs available only on the orders of a physician please refer to the *Eligible health services under your plan –Outpatient prescription drug section*

Orthotic devices

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

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

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

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

Coverage includes:

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

Osteoporosis

Eligible health services include services to detect and prevent osteoporosis for any of the following:

- A postmenopausal woman not receiving estrogen replacement therapy
- An individual with one or more of the following conditions:
    - Vertebral abnormalities
    - Primary hyperparathyroidism
    - A history of bone fractures
- An individual who meets one or more of the following:
    - Is receiving long-term glucocorticoid therapy
    - Is being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Prosthetic devices

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

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

Prosthetic device means:

- A medical device which replaces all or part of an internal body organ or an external body part lost or impaired as the result of disease, congenital defect or **injury**

Coverage includes:

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

Vision care

Pediatric vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

Vision care supplies

We provide vision eyewear coverage that can help pay for **prescription** eyeglasses or **prescription** contact lenses. You have access to an extensive network of vision locations. If you have questions, see the *How to contact us for help* section.

Eligible health services include:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses

In any one year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

Adult vision care

Routine vision exams

Eligible health services include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.

9. Outpatient prescription drugs

What you need to know about your outpatient prescription drug covered benefits

Read this section carefully so that you know:

- How to access **network pharmacies**
- **Eligible health services** under your plan
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **preauthorization** requirements apply
- How can I request a medical exception
- Prescribing units

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

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

How to access network pharmacies

How do you find a network pharmacy?

You can find a **network pharmacy** online or by phone. See the *How to contact us for help* section for details.

You may go to any of our **network pharmacies**. If you do not get your **prescriptions** at a **network pharmacy**, your **prescriptions** will not be covered as **eligible health services** under the plan. **Pharmacies** include network **retail**, **mail order** and **specialty pharmacies**.

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

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

Eligible health services under your plan

Eligible health services include any **pharmacy** service that meets these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not listed in the *Exceptions* section.
- They are not beyond any limits in the schedule of benefits.

Your **pharmacy** services are covered when you follow the plan's general rules:

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

Your outpatient **prescription drug** plan is based on the drugs in the **drug guide**. The **drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your pharmacist may substitute **generic prescription drugs** for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available. You can call us at the toll-free number on your ID card or log on to your secure member website at www.texasheatlhaetna.com to see if a **prescription drug** that is not listed on the **drug guide** is covered.

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

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

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

- Limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**
- Limiting the quantity, dosage or day supply
- Requiring a partial fill or denial of coverage

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

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

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

Partial fill dispensing for certain prescription drugs

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

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

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

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**. You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

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

All **prescriptions** and refills over a 30 day supply must be filled at a network **retail pharmacy** or **a** network **mail order pharmacy**.

See the schedule of benefits for details on supply limits and cost sharing.

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

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

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

Specialty prescription drugs typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them. You can access the list of **specialty prescription drugs**. See the *How to contact us for help* section for how.

The initial **prescription** for **specialty prescription drugs** must be filled at a network **retail** or **specialty pharmacy**.

Specialty prescription drugs may fall under various drug tiers regardless of their names. See the schedule of benefits for details on supply limits and cost sharing.

Other services
Preventive contraceptives
Your outpatient **prescription drug** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs. See the *How to contact us for help* section for how.

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

We also cover **brand-name prescription drugs** and devices. If you choose a **brand-name prescription drug** or device when a **generic prescription drug** or device is available, you may have to pay a cost share.

See the *Schedule of benefits.*

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

Diabetic supplies

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

- Diabetic needles, syringes and pens
- Test strips – blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs

See the *Specific conditions - Diabetic equipment, supplies and education* section for coverage of blood glucose meters and insulin pumps and for diabetic supplies that you can get from other **providers**.

Nutritional supports

Eligible health services include coverage for 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.

For purposes of this benefit, "low protein modified food product" means foods 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. This includes coverage for amino-acid based elemental formula.

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.).
  - *The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium.*

- Use for your symptom(s) is 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 is 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.
  - The dosage is proven safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial is published in a peer reviewed medical journal.

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

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication. Coverage for oral anti-cancer **prescription drugs** will not be less favorable than for intravenously or injected anti-cancer **prescription drugs**. Your **prescriber** or your pharmacist may need to get approval from us before we will agree to cover the drug for you. See the *Preauthorization* section for details.

Over-the-counter drugs

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

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

Eligible health services include **prescription drugs** used to treat people who are at:

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

Tobacco cessation prescription and over-the-counter drugs

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

How you get an emergency prescription filled

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

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

Where your schedule of benefits fits in

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

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

- The type of **prescription** you use
- Where you fill your **prescription**

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

What preauthorization requirements apply

Why do some drugs need preauthorization?

For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**preauthorization**". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are **medically necessary**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

There is another type of **preauthorization** for **prescription drugs**, and that is **step therapy**. You will find the **step therapy prescription drugs** on the **drug guide**. For the most up-to-date information, call us or go online. See the *How to contact us for help* section for details.

How can I request a prescription drug exception?

Sometimes you or your **prescriber** may ask for a medical exception to get coverage for drugs not covered or for **brand-name**, **specialty** or **biosimilar prescription drugs** or for which **prescription drugs** are denied through **preauthorization** or **step therapy**. You, someone who represents you or your **prescriber** can contact us. You will need to provide us with the required clinical documentation. We will make a coverage determination within 72 hours after we receive your request and any information that supports it and will tell you and your **prescriber** of our decision. Any exception granted is based upon an

individual, case by case decision, and will not apply to other members. If approved by us, you may receive the non-preferred benefit level and the exception will apply for the entire time of the **prescription**.

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

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- Submitting the request in writing to CVS Health ATTN: **Texas Health + Aetna Health** PA, 1300 E Campbell Road Richardson, TX 75081

We will make a coverage determination within 24 hours after we receive your request and will tell you, someone who represents you and your **prescriber** of our decision. If approved by us, the exception will apply for the entire time you have an urgent situation.

If you are denied a **prescription drug** exception based on the above processes, you may have the right to a third party review by an independent review organization. If our claim decision is one that allows you to ask for an independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. We will tell you, someone who represents you or your **prescriber** of the coverage determination of the independent review within 72 hours after we receive your request. If the **prescription drug** exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker **prescription drug** exceptions in urgent situations, we will tell you, someone who represents you or your **prescriber** of the coverage determination within 24 hours after we receive your request. If the quicker **prescription drug** exception is approved, coverage will be provided for the entire time you have an urgent situation.

Please see the *When you disagree – claim decisions and appeal procedures* section for your rights when appealing an adverse determination regarding **prescription drugs** or intravenous infusions you are currently receiving.

Prescribing units

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

Any **prescription drug** that is made to work beyond one month shall require the number of **copayments** per **prescription** that is equal to the anticipated duration of the medication. For example, one injection of a drug that works for three months would require three **copayments**.

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

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

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. In that section we also told you that some health care services and supplies have exceptions and some are not covered at all (exclusions). For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exceptions and exclusions that apply to your plan.

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

Exceptions and exclusions

The following are not **eligible health services** under your plan except as described in the *Eligible health services under your plan* section of this EOC or by a rider or amendment included with this EOC:

Acupuncture, **acupressure and acupuncture therapy**.

Ambulance services

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services
- Fixed wing air **ambulance** transportation from an **out-of-network provider**, except where described in the *Eligible health services under your plan - Ambulance service* section.

Artificial organs

- Any non-FDA approved device that would perform the function of a body organ

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, (except as described in the *Eligible health services under your plan – Hospital care* section

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you

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

Cosmetic services and plastic surgery

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

Counseling

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

Court-ordered services and supplies

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

Custodial care

Examples are:

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

Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Massage table
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators

- Communication aids
- Vision aids
- Telephone alert systems

Early intensive behavioral interventions
Examples of those services are:
- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Educational services
Examples of those services are:
- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs.
- Services provided by a school district.

Emergency services and urgent care
- Non-emergency care in a **hospital** emergency room facility, freestanding emergency medical care facility or comparable emergency facility
- Non-urgent care in an **urgent care facility** or at a non-**hospital** freestanding facility

Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational
- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs)

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a person’s main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other

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

Foot care

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

Growth/Height care

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

Hearing aids, except as described in the *Eligible health services under your plan – Hearing aids and Cochlear implants and related services* sections

Home health 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

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

Jaw joint disorder

- Non-surgical treatment of **jaw joint disorder**
- **Jaw joint disorder** treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutic services related to **jaw joint disorder**

Maintenance care

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

Medical supplies – outpatient disposable

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

Mental health treatment

- Mental health 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)):
  - Stay in a facility for treatment for dementias or amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special educational, remedial education, wilderness treatment programs or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Obesity (bariatric) surgery and weight management

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
  - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of, obesity, including **morbid obesity**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications

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

Orthotic devices

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

Other primary payer

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

Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products

Outpatient prescription drugs

- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids
- **Cosmetic** drugs
    - Medications or preparations used for **cosmetic** purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA), including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
    - Administered or entirely consumed at the time and place it is prescribed or dispensed
    - Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated in the *Eligible health services under your plan – Outpatient prescription drugs* section
    - That includes the same active ingredient or a modified version of an active ingredient
    - That is therapeutically equivalent or a therapeutic alternative to a covered **prescription drug** unless a **prescription drug** exception is approved
    - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a **prescription drug** exception is approved
    - Provided under your medical benefits while an inpatient of a healthcare facility
    - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Texas Health + Aetna Health's** Pharmacy and Therapeutics Committee
    - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
    - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)

- Not approved by the FDA or not proven to be safe and effective
    - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **preauthorization** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
    - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents
- Implantable drugs and associated devices except where stated in the *Eligible health services under your plan – Preventive care and wellness* and *Outpatient prescription drugs* section
- **Infertility**
    - Injectable **prescription drugs** used primarily for the treatment of **infertility**
- Injectables:
    - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
    - Needles and syringes, except those used for self-administration of an injectable drug.
    - For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps. See the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.
- **Prescription drugs**:
    - Dispensed by other than a network **retail**, **mail order** and **specialty pharmacies**.
    - Dispensed by an out-of-network **mail order pharmacy**, except in a medical emergency or urgent care situation.
    - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
    - Filled prior to the effective date or after the end date of coverage under this plan.
    - Dispensed by a **mail order pharmacy** that includes **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
    - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
    - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition unless dental benefits are provided under the plan.
    - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.

  - That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **drug guide** or the product on the **drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
  - That are not covered or related to a non-covered service.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card.
- Refills
  - Refills dispensed more than one year from the date the latest **prescription** order was written
- Replacement of lost or stolen **prescriptions**
- Tobacco use
  - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Eligible health services under the plan – Outpatient prescription drugs* section.
- Test agents except diabetic test agents

Outpatient surgery

- A **stay** in a **hospital**. (A **hospital stay** is an inpatient **hospital** benefit. See *the Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician's** office.
- Services of another **physician** for the administration of a local anesthetic.

Pediatric dental care

In addition to the exclusions that apply to health coverage:

- Any instruction for diet, plaque control and oral hygiene
- **Cosmetic** services and supplies including:
  - Plastic **surgery**, reconstructive **surgery**, **cosmetic surgery**, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services under your plan* section
  - Facings on molar crowns and pontics will always be considered **cosmetic**
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge

- Dental implants and braces (that are determined not to be **medically necessary**), mouth guards and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
    - For splinting
    - To alter vertical dimension
    - To restore occlusion
    - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic **surgery**, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **eligible health service**
- Orthodontic treatment except as covered in the *Eligible health services under your plan – Pediatric dental care* section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically described in the *Eligible health services under your plan – Pediatric dental care* section
- Services and supplies:
    - Done where there is no evidence of pathology, dysfunction or disease other than covered preventive services
    - Provided for your personal comfort or convenience or the convenience of another person, including a **provider**
    - Provided in connection with treatment or care that is not covered under your plan
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a **dental provider**

Dental care for adults

- Dental services for adults, including services related to:
    - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
    - Dental services related to the gums
    - Apicoectomy (dental root resection)
    - Orthodontics
    - Root canal treatment
    - Removal of soft tissue impactions
    - Alveolectomy
    - Augmentation and vestibuloplasty treatment of periodontal disease
    - False teeth
    - Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Personal care, comfort or convenience items

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

Physician surgical services

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

Private duty nursing

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Repair and replacement due to loss, misuse, abuse or theft

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services

Strength and performance

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

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - 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 as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation

Except where described in this EOC:

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

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing **illness**
- Outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence
- Harvesting and/or storage of bone marrow or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**

Treatment in a federal, state, or governmental entity

Except where required by law:

- Charges you have no legal obligation to pay
- Charges that would not be made if you did not have coverage under the plan

Treatment of infertility

All charges associated with the treatment of infertility, except as described under the *Eligible health services under your EOC*. This includes:

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

Vision care

Adult vision care

- Vision care services and supplies

Pediatric vision care services and supplies

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

- Special supplies such as non-**prescription** sunglasses
- Non-**prescription** eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses
- Eyeglass frames, **prescription** lenses and **prescription** contact lenses that are not identified as preferred by a vision **provider**
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your **stay** in a **hospital** or other facility for health care
- Eye exams for contact lenses or their fitting
- Acuity tests

- Eye **surgery** for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Wilderness treatment programs

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

Work related illness or injuries

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

Who provides the care

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

Network providers

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

For you to receive the network level of benefits, you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section.
- Urgent care – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section and to the schedule of benefits.
- **Network provider not reasonably available** – You can get **eligible health services** under your plan that are provided by an **out-of-network provider** if an appropriate **network provider** is not reasonably available. You must ask to use the **out-of-network provider** in advance and we must agree.
- We will make a decision as soon as your medical condition requires but no later than 5 working days after we receive all of the information we need from your **provider**. . We may decide not to approve your request. Before we disapprove the request, a **specialist** of the same or similar specialty as the **provider** you are requesting to see will review your request. If access is approved, we will pay the **out-of-network provider** at our usual and customary charge or at an agreed rate. We will work with the **provider** so that all you pay is the appropriate network level **copayment**. See the *How to contact us for help* section for assistance.

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

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

Your PCP

For you to receive the network level of benefits, **eligible health services** must be accessed through your **PCP's** office. They will provide you with primary care.

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

- General practitioner
- Family **physician**
- Internist

- Pediatrician
- OB, GYN, and OB/GYN

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

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

Designation of your network **specialist** as your **PCP** will not be retroactive. If your request is denied, you may appeal the decision. See the *When you disagree - claim decisions and appeal procedures* section.

How do you choose your PCP?

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

Each covered family member is required to select a **PCP**. You may each select 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 will your PCP do for you?

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

Your **PCP** can also:

- Order lab tests and radiological services
- Prescribe medicine or therapy
- Arrange a **hospital stay** or a **stay** in another facility

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

How do I change my PCP?

You may change your **PCP** at any time. You can call us at the number on your ID card or log on to your secure member website at www.texashealthaetna.com to make a change.

What happens if I 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.

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

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

- You join the plan and the **provider** you have now is not in the network
- You are already a member of **Texas Health + Aetna Health** and your **provider** stops being in our network

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

	If you are a new enrollee and your provider is an out-of-network provider	**If you are a current enrollee and when your provider stops participation with Texas Health + Aetna Health**
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the **provider** terminated their participation with **us**.
How claim is paid	Your claim will be paid at the **network provider** cost sharing level.	
	If you have a disability, acute condition, or life-threatening condition and your provider stops participation with Texas Health + Aetna Health	
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the toll-free number on your ID card for information on continuity of care.	
Length of transitional period	Care will continue during a transitional period for up to 90 days. This date is based on the date the **provider** terminated their participation with **us**.	
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.	

	If you have a terminal illness and your provider stops participation with Texas Health + Aetna Health
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the toll-free number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to 9 months. This date is based on the date the **provider** terminated their participation with **us**.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Texas Health + Aetna Health
Request for approval	Your **provider** should call us for approval to continue any care. You can call Member Services at the toll-free number on your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within 6 weeks.
How claim is paid	Your claim will be paid at not less than the network contract rate during the transitional period.

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

What the plan pays and what you pay

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

- Your **copayments**
- Your **maximum out-of-pocket limit**

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

The general rule

The schedule of benefits lists how much the plan pays and how much you pay for each type of health care service. In general, when you get **eligible health services**:

- The plan and you share the expense up to any **maximum out-of-pocket limit**. Your share is called a **copayment**

And 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 **negotiated charge** for a **network provider**. See the *Glossary* section for what these terms mean.

Important note – when your plan pays all

Your plan pays the entire expense for all in-network **eligible health services** under the preventive care and wellness benefit.

Important note – when you pay all

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

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity, referral and preauthorization requirements* section.
- When your plan requires **preauthorization**, it was requested, we refused it, and you get an **eligible health service** without **preauthorization**. See the *Medical necessity, referral and preauthorization requirements* section.
- When you get an **eligible health service** without a **referral** when your plan requires a **referral**. See the *Medical necessity, referral and preauthorization requirements* section.
- Usually, when you get an **eligible health service** from someone who is not a **network provider**. See the *Who provides the care* section.

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

Special financial responsibility

You are responsible for the entire expense of cancelled or missed appointments.

Neither you nor we are responsible for charges, expenses or costs in excess of the **negotiated charge**.

Where your schedule of benefits fits in

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

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

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

When you disagree - claim decisions and appeal procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim) When you have received a service from an eligible **provider**, you will be charged. The information you receive for that service is your proof of loss.	• A completed claim form and any additional information required by us.	• No later than 90 days after you have incurred expenses for **covered benefits**. • We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly, but no later than 5 business days after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received, • If we pay or deny a claim we will notify you no later than 15 business days after the receipt of necessary proof to support the claim. • A delay of a claim payment will not exceed 60 days.

Types of claims and communicating our claim decisions

Your **network provider** will send us a claim on your behalf. We will review that claim for payment to the **provider**.

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

Urgent care claim

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

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

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **preauthorize** them.

Retrospective claim

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

Concurrent care claim extension

A concurrent care claim extension happens when you ask us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**.

Concurrent care claim extension decision

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

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

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

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

Type of notice	**Initial determination (us)**	**Extensions**	**Additional information request (us)**	**Response to additional information request (you)**
Pre-service claim*	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Concurrent care claim* If you are hospitalized (may include concurrent care claim of **hospital stays**)	No later than 24 hours after we receive the request, followed by written notification within 3 business days	Not applicable	Not applicable	Not applicable
If you are not hospitalized	No later than 3 calendar days after we receive the request	Not applicable	Not applicable	Not applicable
Care to make sure you are stable following emergency treatment (post-stabilization) or for a life-threatening condition	No later than 1 hour after we receive the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (non-emergency)	No later than 72 hours after **Aetna** receives the request	Not applicable	Not applicable	Not applicable
Requests for **step therapy** exception (emergency)	No later than 24 hours after **Aetna** receives the request	Not applicable	Not applicable	Not applicable

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

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

Adverse determinations

We pay many claims at the full rate **negotiated charge** with a **network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim that is an "adverse determination" or "adverse decision". It is also an "adverse determination" if we rescind your coverage entirely.

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

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

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

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

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

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

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

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

The difference between a complaint and an appeal

A complaint

A complaint is any oral or written expression of dissatisfaction regarding any aspect of our operation. You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the toll-free number on your ID card or write us. See the *How to contact us for help* section. Some other examples of complaints are when you are not happy with:

- How we have administered the plan
- How we have handled the appeal process

- When we deny a service that is not related to **medical necessity** issues
- The manner in which a service is provided
- A disenrollment decision

But it is not a complaint if:
- We resolve a misunderstanding or misinformation, to your satisfaction, by providing an explanation or more information.
- You or your **provider** call or write to tell us you are unhappy with, or disagree with, an adverse determination. Instead, this is an appeal of the adverse determination. See the *Appeal of adverse determinations* and *Timeframes for deciding appeals of adverse determinations* sections for more information.

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

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. If your complaint is for services that you have not already received, we will provide you with a written response within 15 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

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

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

Appeal of a complaint
You can ask us to re-review your complaint. You can appeal to us by calling the toll-free number on your ID card or by writing Member Services.

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

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

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

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

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

- The panel will review the information and provide us with their decision. We will send you the final decision in writing within 30 calendar days of receiving the appeal. If your appeal is for services that you have not already received, we will send you the final decision in writing within 15 calendar days of receiving the appeal. The letter will include: The date we received the appeal request
- The panel's understanding of your complaint and the facts
- The clinical basis and criteria used to make the decision
- Documents supporting the decision
- If applicable, a statement of your right to request an independent review
- A statement of your right to appeal to the Department of Insurance at:

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

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

Appeals of adverse determinations

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

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

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

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

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

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

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

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

Timeframes for deciding appeals of adverse determinations

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

Type of claim	Our response time from receipt of appeal
Urgent care claim	1 business day
Emergency medical condition	As soon as possible but not later than one 1 business day
When you need care to make sure you are stable following emergency treatment (post-stabilization)	No later than one (1) hour after the request
If you are hospitalized at the time of the adverse determination (may include concurrent care claim of **hospital stays**)	No later than 1 business day*
If you are receiving **prescription drugs** or intravenous infusions	As soon as possible but not later than 1 business day
Pre-service claim requiring **preauthorization**	As soon as possible but not later than 15 calendar days*
Requests for **step therapy** exception (non emergency)	Within 72 hours after **Aetna**

Type of claim	Our response time from receipt of appeal
	receives the request
Requests for **step therapy** exception (emergency)	Within 24 hours after **Aetna** receives the request
Acquired brain **injury**	No later than 3 business days after the request
Retrospective claim	As soon as possible but not later than 30 calendar days*

*If your appeal is denied, your **provider** may ask us in writing to have a certain type of specialty **provider** review your case. The request must show good cause for specialty review. The request must be made not later than 10 business days after the appeal was denied. A **provider** of the same or a similar specialty who would typically manage this type of condition will do the review. A decision will be made within 15 working days of the date we receive such a request.

Exhaustion of appeals process

In most situations, you must complete an appeal with us before you can take these other actions:

- Appeal through an independent review process.
- Pursue voluntary arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the appeals process before you may take other actions. These are when:

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

Independent review

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

You have a right to independent review only if:

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

If our claim decision is one for which you can seek independent review, we will say that in the notice of adverse determination we send you. That notice also will describe the independent review process. It will include a copy of the Request for Review by an Independent Review Organization (IRO) form.

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

- To **Texas Health + Aetna Health**
- And you must include a copy of the notice from us and all other important information that supports your request

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

Texas Health + Aetna Health send your independent review request to the Texas Department of Insurance (TDI). The TDI will assign it to an IRO and notify us of the assignment. We will send your request and supporting information to the assigned IRO no later than the third business day after we receive it.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision

We will stand by the decision that the IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

The IRO will notify you of their decision. The amount of time they have to make their decision is based on the services you are requesting. The chart below tells you how much time the IRO has to review your request.

IRO Decisions	
When your request involves:	**The IRO will notify you within:**
Emergency services	72 hours
Prescription drugs or intravenous infusions you are currently receiving	72 hours
Any other service	The earlier of: • 15 days after the IRO receives all necessary information • 20 days after the IRO receives the request

Recordkeeping

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

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal. But we will pay the fees or expenses incurred for the review of the IRO.

Coordination of benefits

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

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

Key terms

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

<table>
<tr><td colspan="2">Plan:
A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.</td></tr>
<tr><td>• It includes:</td><td>• Group, blanket or franchise accident and health insurance policies, excluding disability income protection coverage
• Individual and group health maintenance organization evidences of coverage
• Individual accident and health insurance policies
• Individual and group preferred provider benefit plans and exclusive provider benefit plans
• Group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care
• Medical care components of individual and group long-term care contracts
• Limited benefit coverage that is not issued to supplement individual or group in-force policies
• Uninsured arrangements of group or group-type coverage
• The medical benefits coverage in automobile insurance contracts
• Medicare or other governmental benefits, as permitted by law</td></tr>
<tr><td>• It does not include:</td><td>• Disability income protection coverage
• The Texas Health Insurance Pool
• Workers' compensation insurance coverage
• Hospital confinement indemnity coverage or other fixed indemnity coverage
• Specified disease coverage
• Supplemental benefit coverage
• Accident only coverage</td></tr>
</table>

<table>
<tr><td></td><td>Specified accident coverage
School accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis
Benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
Medicare supplement policies
A state plan under Medicaid
A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan
Other nongovernmental plan
An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible</td></tr>
<tr><td colspan="2">Each plan for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">This plan:
This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans</td></tr>
<tr><td>How this plan coordinates with like benefits:</td><td>Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.</td></tr>
<tr><td>The order of benefit determination rules for this plan:</td><td>The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.
When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits
When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100% of the total allowable expense</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Allowable expense:
Allowable expense is a health or dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person.</td></tr>
<tr><td>Allowable expense for benefits provided in the form of services:</td><td>When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.</td></tr>
</table>

• Expenses that are not allowable expenses:	An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a **provider** or **physician** by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Some expenses and services are not allowable expenses. Here are some examples: • The difference between the cost of a semi-private **hospital** room and a private **hospital** room is not an allowable expense, unless one of the plans provides coverage for private **hospital** room expenses. • If a person is covered by two or more plans that don't have a **negotiated charge** and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense. • If a person is covered by two or more plans that provide benefits or services on the basis of **negotiated charges**, an amount in excess of the highest of the **negotiated charges** is not an allowable expense. • If a person is covered by one plan that does not have **negotiated charges** and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides it benefits or services based on **negotiated charges**, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care **provider** or **physician** has contracted with the secondary plan to provide the benefit or service for a specific **negotiated charge** or payment amount that is different than the primary plan's payment arrangement and if the health care **provider's** or **physician's** contract permits, the **negotiated charge** or payment must be the allowable expense used by the secondary plan to determine its benefits. • The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, **preauthorization** of admissions, and **network provider** and **physician** arrangements.

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

Order of benefit determination rules

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

• The primary plan pays according to its terms of coverage and without regard to the benefits under any other plan.
• A plan that does not have a COB provision is always primary unless the provisions of both plans state that the complying plan is primary, except: – Coverage that you have because of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the **contract holder**. Examples of these types of situations are: o Major medical coverages that are superimposed over base plan **hospital** and **surgical** benefits o Insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
• A plan may consider the benefits paid by another plan in calculating payment of its benefits only when it is secondary to that other plan.
• If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay benefits as if it were the primary plan when a covered person uses an **out-of-network provider** or **physician**, except for **emergency services** or authorized **referrals** that are paid or provided by the primary plan.
• When multiple contracts providing coordinated coverage are treated as a single plan, this applies only to the plan as a whole. Coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with these rules.
• If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which secondary plan's benefits are determined in relation to

each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

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

If you are:	**Primary plan**	**Secondary plan**
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Eligible for Medicare	If you or a dependent have Medicare coverage, the rule above may be reversed so that the plan covering you or your dependent is the secondary plan and the other plan is the primary plan. An example includes a retired employee. See the *How to contact us for help* section if you have questions.	
COB rules for dependent children Unless there is a court order stating otherwise, the order of benefits is determined using the following rules that apply.		
Child of: • Parents who are married or living together, whether or not they have ever been married	The “birthday rule” applies. The plan of the parent whose birthday[+] (month and day only) falls earlier in the **calendar year**. [+]Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)[+]. [+]Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan.	The plan of the other parent. But if that parent has no coverage, then his/her spouse’s plan is primary.
Child of: • Parents separated or divorced or not living together, whether or not they have ever been married – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	

<table>
<tr><td>Child of:
• Parents separated or divorced or not living together, whether or not they have ever been married and there is no court-order</td><td colspan="2">The order of benefit payments is:
• The plan of the custodial parent pays first
• The plan of the spouse of the custodial parent (if any) pays second
• The plan of the noncustodial parent pays next
• The plan of the spouse of the noncustodial parent (if any) pays last</td></tr>
<tr><td>Child covered by:
• Individual who is not a parent (i.e. stepparent or grandparent)</td><td colspan="2">Treat the person the same as a parent when making the order of benefits determination:

See Child of content above.</td></tr>
<tr><td>Child of:
Persons who are not his or her parents</td><td colspan="2">The rules shown for parents will apply, as if the persons were parents of the child.</td></tr>
<tr><td>Child of:
Parents, who is also covered under a spouse’s plan</td><td colspan="2">The plan that has covered the person longer is primary.

If coverage under the plans began on the same date, primary and secondary coverage is based on the birthday rule of the parents and spouse.</td></tr>
<tr><td>Active or inactive employee

This rule does not apply if:
• The plan that covers you as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits
• The “Covered under the plan as an employee, retired employee or dependent” row above can determine the order of benefits</td><td>The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).</td><td>A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).</td></tr>
</table>

<table>
<tr><td>COBRA or state continuation

This rule does not apply if:
• The other plan does not have this rule, and as a result, the plans do not agree on the order of benefits
• The “Covered under the plan as an employee, retired employee or dependent” row above can determine the order of benefits</td><td>The plan covering you as an employee or retiree, or the dependent of an employee or retiree, is primary to COBRA or state continuation coverage.</td><td>COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree, or the dependent of an employee or retiree.</td></tr>
<tr><td>Longer or shorter length of coverage</td><td colspan="2">If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.</td></tr>
<tr><td>Other rules do not apply</td><td colspan="2">If none of the above rules apply, the plans share expenses equally.

This plan will not pay more than it would have paid had it been the primary plan.</td></tr>
</table>

Effect on the benefits of this plan

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

Compliance with federal and state laws concerning confidential information

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

Facility of payment

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

Right of recovery

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

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly. See the *How to contact us for help* section for details.

Recovery rights related to workers' compensation

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

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

The recovery rights will be applied even if:

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

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

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

When coverage ends

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

When will your coverage end?

Reason for ending coverage	When coverage ends
• Your employer does not pay the required **premium** payment by the end of the grace period	The last date for which **premium** was paid, or as of the date required by law
• You commit fraud	30 days after we notify you of the termination
• You are no longer eligible for coverage including, including when you no longer reside, live, or work in the **service area**	30 days after we notify you of the termination
• This product is discontinued in the state, if approved by the insurance department of the state where this EOC was issued	90 days after we notify you of the termination
• This EOC is discontinued	90 days after we notify you of the termination
• We withdraw from the individual market in the state, if approved by the insurance department of the state where this EOC was issued	180 days after we notify you of the termination

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- You do not make the required **premium** contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed in the table above

Important Note:
Your employer will notify **Texas Health + Aetna Health** of the date your coverage ends. Except as stated above, you and your dependents will be covered until the end of the month after we receive the notice, unless any of the following occur:

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

What happens to your dependents if you die?

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

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

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

We will not end your coverage based on your health care status or needs. We also will not end your coverage because you used your rights under the *When you disagree – claim decisions and appeal procedures* section of this EOC.

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because: • Your job has been eliminated • You have been placed on severance • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your coverage ends* section.
Your employment ends because of a military leave of absence.	If **premium** payments are made for you, you may be able to continue to coverage under the plan as long as the **contract holder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **contract holder** but not beyond 24 months from the start of the absence.

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

Special coverage options after your coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a "qualifying event". COBRA usually applies to employers of group sizes of 20 or more. Talk with your employer if you have questions about this.

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

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

When do I receive COBRA information?

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

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

You/your dependents notification requirements		
Notice of qualifying event – qualified beneficiary	Notify your employer if: • You divorce or legally separate and are no longer responsible for dependent coverage • Your covered dependent children no longer qualify as a dependent under the plan	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later

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

How can you extend the length of your COBRA coverage?

The chart below shows qualifying events after the start of COBRA (second qualifying events):

Qualifying event	Person affected (qualifying beneficiary)	Total length of continued coverage
You were disabled during the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
• You die • You divorce 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 dependent under the plan	You and your dependents	Up to 36 months

How do you enroll in COBRA?
You enroll by sending in an application and paying the **premium**. Your employer has 14 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

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

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% covers administrative fees. If you apply for COBRA because of a disability, the total due will change to 150% of the plan costs in your 19th month of COBRA.

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

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

When does COBRA coverage end?
COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

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

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

When do I receive state continuation information?
The chart below lists who must give the notice, the type of notice required, and the time period to give the notice.

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

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

Group continuation privilege

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

- Involuntary termination for cause
- Discontinuance of the group agreement

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

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

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

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

You can continue coverage until the earliest of:

- Six months after the end of the COBRA continuation period, if you are eligible for COBRA
- Nine months after the date the election is made, if you are not eligible for COBRA
- The date you fail to pay **premiums**

- The date the group coverage terminates in its entirety
- The date you are covered for similar benefits by another health insurance policy or program
- The date you are covered (other than COBRA) for similar benefits by another plan

Continuation of coverage for other reasons

To request an extension of coverage, just call the toll-free number on your ID card.

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

Your coverage may be extended if you or a dependent 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 own occupation or any other occupation for pay or profit.

A 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 the dependent are no longer totally disabled
- When you become covered by another health benefits plan

How can you extend coverage when getting inpatient care when coverage ends?

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

Benefits are extended only for the **hospital** or **skilled nursing facility stay**. Benefits aren't extended for other medical conditions.

Benefits will be extended until the earliest of:

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

What exceptions are there for dental work completed after your coverage ends?

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

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures

- Fixed partial dentures (bridges)
- Root canals

Ordered means:

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

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

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

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

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

If your coverage ends while you are not totally disabled, your plan will cover vision services and supplies for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction.

The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in **prescription**.

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

You have the right to extend coverage for your dependent **child** beyond the plan age limits. If your disabled **child**:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly on you for support

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled, and your coverage under the group agreement remains in effect.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

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

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 according to other federal and state laws that apply. You and we will interpret it according to these laws.

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

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

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

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

Entire contract

The following documents make up the entire contract between you and us:

- Group application
- Group agreement
- EOC
- Schedule of benefits
- Amendments
- Riders

Any change in the contract must be approved by an **Texas Health + Aetna Health** officer. The change to the contract must be attached to the contract. No other person may change the form or waive any of the provisions.

Coverage and services

Your coverage can change

Your coverage is defined by the **HMO agreement**. This document may have amendments or riders too. Under certain circumstances, we or your employer or the law may change your plan. But only as permitted by the **HMO agreement** Only we may waive a requirement of your plan. No other person – including your employer or **provider** – can do this.

If a service cannot be provided to you

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

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

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 **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

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

Honest mistakes and intentional deception

Honest mistakes

You or your employer may make an honest mistake in your application for coverage 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 effects on your coverage. These 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.

You have special rights if we terminate your coverage.

- We will give you at least 30 days advanced written notice of any termination of coverage.
- You have the right to an **Texas Health + Aetna Health** appeal.
- You have the right to a third party review conducted by an independent review organization.

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

Some other money issues

Assignment of benefits

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

Recovery of overpayments

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

When you are injured by a third party

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

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

- You are agreeing to repay us from money you receive from those third parties because of your **injuries**.
- You are giving us a right to seek money in your name, from those third parties because of your **injuries**. You are agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money from those third parties for your **injuries** or **illness**. You'll hold any money you receive until we are paid in full. And you'll give us the right to our portion of the money you get, ahead of everyone else.
- You are agreeing to provide us notice of any money you will be receiving before pay out or within 5 days of when you receive the money. Notify us by calling Member Services at the toll-free number on your member ID card

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

If you are not represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, or
- The total amount paid by us

If you are represented by an attorney, then we can recover the lesser of:

- One-half of the money you receive, less attorney’s fees and costs for the recovery, or
- The total amount paid by us, less attorney’s fees and costs for the recovery

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

Your health information

We will protect your health information. We use and share it to help us process your claims and manage your EOC. You can get a free copy of our Notice of Privacy Practices. Just call the toll-free number on your ID card. When you accept coverage under the EOC, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

Glossary

Ambulance

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

Behavioral health provider

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

Biosimilar prescription drug

A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) – licensed reference biological **prescription drug**, even though there may be minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug. As defined in accordance with FDA regulations.

Brand-name prescription drug

An FDA approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year

A period of 12 months that begins on January 1st and ends on December 31st.

Contract holder

An employer or organization who agrees to remit the **premiums** for coverage under the group agreement payable to **Texas Health + Aetna Health**. The **contract holder** is an agent of **Texas Health + Aetna Health members** in the employer group, and not an agent of **Texas Health + Aetna Health** for any other purpose.

Copay, copayment

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

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible health services that meet the requirements for coverage under the terms of this plan.

Crisis stabilization unit

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

Custodial care

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

Dental provider

Any individual legally qualified to provide dental services or supplies.

Detoxification

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

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

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

Directory

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

Drug guide

A list of **prescription drugs** and devices for which **AetnaTexas Health + Aetna Health** or an affiliate provides coverage, approves payment and encourages or offers incentives. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Texas Health + Aetna Health** or an affiliate only upon renewal and with 60 days notice to you. A copy of the **drug guide** is available at your request. Or you can find it on the **Texas Health + Aetna Health** website at www.texashealthaetna.com/formulary.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

Effective date of coverage
The date your and your dependents' coverage, if your plan includes coverage for dependents, begins under this EOC as noted in our records.

Eligible health services
The health care services and supplies listed in the *Eligible health services under your plan* section and not listed or limited in the *Exceptions* section or in the schedule of benefits.

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

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious jeopardy to the health of the fetus
- Serious disfigurement

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

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

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

Generic prescription drug, generic drug
A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

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

- The group application

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

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

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

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

Hospice care
Supportive care given to people in the final phase of a **terminal illness** with a focus on comfort and quality of life, rather than cure.

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

Hospice care program
A program prescribed by a **physician** or other **health professional** to provide **hospice care** and support to a person with a **terminal illness** and their families.

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

Hospital
An institution licensed as a **hospital** by applicable state and federal laws and accredited as a **hospital** by The Joint Commission (TJC).

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**

- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

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

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

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

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

Intensive outpatient program (IOP)
Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho-educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder
This is:
- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A Myofascial Pain Dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

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

Maximum out-of-pocket limit
This is the most you will pay per year in **copayments**, if one applies, for **eligible health services** as listed in the schedule of benefits.

Medically necessary, medical necessity
Health care services that we determine a **provider** using sensible 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 the same benefit 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 based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

Mental disorder
Mental disorders are defined in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a book published by the American Psychiatric Association. It describes all recognized **mental disorders**. In general, a **mental disorder** is a serious disturbance in a person's thought process, emotions or behavior that causes problems in mental functioning. **Mental disorders** are often connected to significant distress or disability in social, work or other important activities.

Morbid obesity
This means the body mass index is well above the normal range (greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared) and severe medical conditions may also be present, such as:

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

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

Negotiated charge

For health coverage, this is either:

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

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

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any **prescription drug**.

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

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

The **negotiated charge** does not reflect any amount an affiliate or we may receive under a rebate arrangement between us, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **drug guide**.

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

Network provider

A **provider** listed in the **directory** for your plan. However, a National Advantage Program (NAP) **provider** listed in the NAP **directory** is not a **network provider**.

Network pharmacy

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

Non-preferred drug

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

Out-of-network provider

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

Partial hospitalization treatment

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

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

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

Pharmacy

An establishment where **prescription drugs** are legally dispensed. This can be a **retail**, **mail order** or **specialty pharmacy**.

Physician

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

Preauthorization, preauthorize

A requirement that you or your **physician** contact us before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Preferred drug

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

Premium

The amount you or your employer is required to pay to **Texas Health + Aetna Health** for your coverage.

Prescriber

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

Prescription

As to hearing care:
A written order for the dispensing of **prescription** electronic hearing aids by otolaryngologist, otologist or audiologist.

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

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

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

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

- The **directory** lists as a **PCP** and is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician
- Initiates **referrals** for **specialist** care and maintains continuity of patient care
- Is shown on our records as your **PCP**

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

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

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

R.N.
A registered nurse.

Referral
For plans that require one, 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 (mental disorders)
An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Texas Health + Aetna Health** or is accredited by one of the following agencies, commissions or committees for the services being provided:

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

- The Council on Accreditation (COA)

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

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

Residential treatment facility (substance abuse)

An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Texas Health + Aetna Health** or accredited by one of the following agencies, commissions or committees for the services being provided:

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

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

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

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

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

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

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

Skilled nursing facility does not include institutions that provide only:
- Minimal care
- **Custodial care** services
- Ambulatory care
- Part-time care services

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

Skilled nursing services
Services provided by an **R.N.** or **L.P.N.** within the scope of his or her 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 access the list of these **specialty prescription drugs**. See the *How to contact us for help* section for details.

Specialty pharmacy
This is a **pharmacy** designated by **Texas Health + Aetna Health** as a network **pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

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

Step therapy

A form of **preauthorization** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Texas Health + Aetna Health** or an affiliate only upon renewal and with 60 days notice to you before the changes take effect. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Texas Health + Aetna Health** website at www.texashealthaetna.com/formulary.

Substance abuse

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

Surgery center

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

Surgery, surgical procedure

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means. This includes:

- Cutting
- Scraping
- Suturing
- Destruction
- Removal
- Lasering

It also includes:

- Introduction of a catheter (e.g. heart or bladder catheterization) or scope (e.g. colonoscopy, endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint or injection of sclerosing solution
- Physically changing body tissues and organs

Telehealth

A health service, other than a **telemedicine** medical service, delivered by a **health professional** licensed, certified or otherwise entitled to practice in the State of Texas and acting within the scope of their license, certification or entitlement to a patient at a different physical location than the **health professional** using telecommunications or information technology.

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

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

Texas Health + Aetna Health
Texas Health + Aetna Health Plan Inc., a Texas corporation holding a certificate of authority from the state of Texas as a health maintenance organization.

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

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

Walk-in clinic
A free-standing health care facility. Neither of the following is considered a **walk-in clinic**:
- An emergency room
- The outpatient department of a **hospital**

Discount programs

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 are not responsible. But, 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 discounted goods or services.

Wellness and other incentives

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as an **Texas Health + Aetna Health** member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

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

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

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

Appendix A

Service Area Maps

Network Analysis - HMO

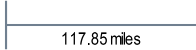
Service Area Overview

August 9, 2017

Created by...
Aetna MSU Department - CN

Service Areas

TX-HMO - Service Area



Health Maintenance Organization (HMO)

Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. If the contract holder is a church group or a government group, this may not apply. Please contact the contract holder for additional information.

Schedule of benefits

This schedule of benefits lists the **copayments**, if any that apply to the **eligible health services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the services.

How to read your schedule of benefits

- You must pay any **copayments**, if they apply.
- You must pay the full amount of any health care service you get that is not a **covered benefit**.
- This plan has limits for some **covered benefits**. For example, these could be visit, day or dollar limits.

Important note:
All **covered benefits** are subject to the **calendar year out-of-pocket maximum**, limits and **copayment** unless otherwise noted in the schedule of benefits below.

How your 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 **eligible health services** for the remainder of that year.

How to contact us for help

We are here to answer your questions:

- Log onto your Aetna Navigator® secure member website at www.texashealthaetna.com
- Call the phone number on your ID card

Texas Health + Aetna Health Plan Inc.'s HMO agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your Evidence of coverage (EOC).

Plan features	Maximums
	In-network coverage

Maximum out-of-pocket limit	
Maximum out-of-pocket limit per year	
Individual	$7,350 per year
Family	$14,700 per year

General coverage provisions

This section explains the **maximum out-of-pocket limit** and limitations listed in this schedule.

Maximum out-of-pocket limits provisions
Eligible health services that are subject to the **maximum out-of-pocket limit** may include **covered benefits** provided under the medical plan and the outpatient **prescription drug** plan.
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.
Individual **maximum out-of-pocket limit** Once you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the year for that person.
Family **maximum out-of-pocket limit** Once you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the remainder 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 **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.
Individual **maximum out-of-pocket limit** Once the amount of the cost share and **deductible** you have paid during for **eligible health services** meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for you for the remainder of the year.
If the **maximum out-of-pocket limit** does not apply to a covered benefit, your cost share for that **covered benefit** will not count toward satisfying the **maximum out-of-pocket limit** amount.
Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include: • All costs for non-covered services • Any out of pocket costs for non-emergency use of the emergency room • Any out of pocket costs incurred for non-urgent use of an **urgent care provider**

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 certificate.

<table>
<tr><th>Eligible health services</th><th>In-network coverage</th></tr>
<tr><td colspan="2">1. Preventive care and wellness</td></tr>
<tr><td>Preventive care and wellness</td><td>0% copay</td></tr>
<tr><td colspan="2">

Routine physical exams - Performed at a physician office
Preventive care immunizations - Performed at a facility or at a physician office
Well woman preventive visits - routine gynecological exams (including pap smears) - Performed at a physician, obstetrician (OB), gynecologist (GYN) or OB/GYN office
Preventive screening and counseling services - Includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - Office visits
Routine cancer screenings - Applies whether performed at a physician, specialist office or facility
Prenatal care services - Provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN
Comprehensive lactation support and counseling services - Facility or office visits
Breast feeding durable medical equipment - Breast pump supplies and accessories
Family planning services –Contraceptive counseling services office visit, devices, voluntary sterilization

</td></tr>
<tr><td colspan="2">Preventive care and wellness benefit limitations</td></tr>
<tr><td colspan="2">Routine physical exams:

Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents
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 up to age 22, 1 exam every 12 months after age 22
High risk Human Papillomavirus (HPV) DNA testing for woman age 18 and older limited to one every 12 months

</td></tr>
<tr><td colspan="2">Preventive care immunizations: Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician.</td></tr>
<tr><td colspan="2">Well woman preventive visits - routine gynecological exams (including pap smears): Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</td></tr>
<tr><td colspan="2">Preventive screening and counseling services: Limitations are per 12 months unless stated below.</td></tr>
<tr><td>Obesity and/or healthy diet</td><td>Unlimited visits from age 0-22, 26 visits every 12 months age 22 or older, of which up to 10 visits may be used for healthy diet counseling</td></tr>
<tr><td>Misuse of alcohol and/or drugs</td><td>Limited to 5 visits every 12 months</td></tr>
<tr><td>Use of tobacco products</td><td>Limited to 8 visits every 12 months</td></tr>
<tr><td>Sexually transmitted infection</td><td>Limited to 2 visits every 12 months</td></tr>
<tr><td>Genetic risk counseling for breast and ovarian cancer</td><td>Not subject to any age or frequency limitations</td></tr>
</table>

Routine cancer screenings - mammograms • One low-dose mammography, including digital mammography and breast tomosynthesis, for females age 35 or older annually • For females of any age, subject to any age, family history and frequency guidelines as set forth in the most current: − Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force − The comprehensive guidelines supported by the Health Resources and Services Administration **Routine cancer screenings:** Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force • The comprehensive guidelines supported by the Health Resources and Services Administration Lung cancer screenings that exceed the cancer-screening limit are covered under the Outpatient diagnostic testing section.
Prenatal care services: Review the *Maternity and related newborn care* section. It will give you more information on coverage levels for maternity care under this plan.
Comprehensive lactation support and counseling services: • Lactation counseling services limited to 6 visits per 12 months either in a group or individual setting • Any visits that exceed the lactation counseling services maximum are covered under **physician** services office visits
Breast feeding durable medical equipment: See the *Breast feeding durable medical equipment* section of the certificate for limitations on breast pump and supplies.
Family planning services: Contraceptive counseling services limited to 2 visits per 12 months in either a group or individual setting

Eligible health services	In-network coverage
2. Physicians and other health professionals	
Physician services	
Office hours visits (non-surgical) non preventive care	$80 **copay**
Telemedicine or **telehealth** consultation by a **physician**	$80 **copay physician** 50% **copay specialist** Covered based on type of service and where it is received
Visit limit per day	None
Specialist office visits	
Office hours visit (non-surgical)	50% **copay**

Telemedicine or telehealth	
Telemedicine or **telehealth** consultation by a **specialist**	$80 **copay physician** 50% **copay specialist** Covered based on type of service and where it is received
Visit limit per day	None
Allergy injections	
Without a **physician** or **specialist** office visit	$80 copay **physician** office or **walk-in clinic** 50% copay **specialist** office Covered based on type of service and where it is received
Allergy testing and treatment	
Performed at a **physician** or **specialist** office visit	$80 **copay physician** 50% **copay specialist** Covered based on type of service and where it is received
Immunizations when not part of the physical exam	
Immunizations when not part of the physical exam	$80 copay **physician** office or **walk-in clinic** 50% copay **specialist** office Covered based on the type of service and where it is received
Medical injectables	
Performed at a **physician** or **specialist** office	50% **copay**
Physician surgical services	
Inpatient surgical services	50% **copay**
Performed at a **physician** or **specialist** office	50% **copay**
Alternatives to physician office visits	
Walk-in clinic visits	
Walk-in clinic non-emergency visit	$80 **copay**
Preventive care immunizations	0% **copay**
Individual screening and counseling services at a walk-in clinic Includes obesity and/or healthy diet counseling, use of tobacco products services	
Individual screening and counseling services	0% **copay**

Limitations:

- Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- For details, contact your **physician**
- Refer to the *Preventive care and wellness* section earlier in this schedule of benefits for limits that may apply to these types of services

Important note:
Not all preventive care services are available at **walk-in clinics**. The types of services offered will vary by the **provider** and location of the clinic. These services may also be obtained from a network **physician**.

Eligible health services	In-network coverage
3. Hospital and other facility care	
Hospital care	
Inpatient **hospital**	50% **copay**
Alternatives to hospital stays	
Outpatient surgery	
Performed in **hospital** outpatient department	50% **copay**
Performed in facility other than **hospital** outpatient department	50% **copay**
Physician services	50% **copay**
Home health care	
Outpatient	50% **copay**
Visit limit per year	Coverage is limited to 60 visits per year.
Hospice care	
Inpatient services	50% **copay**
Outpatient services	50% **copay**
Skilled nursing facility	
Inpatient facility	50% **copay**
Day limit per year	Coverage is limited to 25 days per year.

Eligible health services	In-network coverage
4. Emergency services and urgent care A separate **hospital** emergency room facility (or comparable facility/freestanding emergency medical care facility)or urgent care cost share will apply for each visit to an emergency room facility (or comparable facility/freestanding emergency medical care facility) or an **urgent care provider**.	
Hospital emergency room facility (or comparable facility/freestanding emergency medical care facility)	$1,500 **copay** then 50% **copay**
Non-emergency care in a **hospital** emergency room facility (or comparable facility/freestanding emergency medical care facility)	Not covered
Important note: • **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share (**copayment**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. • You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. • If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room facility (or	

comparable facility/freestanding emergency medical care facility) and you have an emergency room facility (or comparable facility/freestanding emergency medical care facility) **copay**, your **copay** will be waived.	
Urgent medical care at a free standing facility that is not a **hospital**	50% **copay**
Non-urgent use of **urgent care provider** at a free standing facility that is not a **hospital**	Not covered

Eligible health services	In-network coverage
5. Pediatric dental care	
Coverage is limited to covered persons through the end of the month in which the person turns 19	
Type A services	0% **copay**
Type B services	30% **copay**
Type C services	50% **copay**
Orthodontic services	50% **copay**
Dental emergency maximum benefit: For covered dental care services provided for a dental emergency by non-contracting **dental provider**, the plan pays a benefit at the in-network level of coverage.	
Dental benefits are subject to the plan's **maximum out-of-pocket limits**, if any and as explained in this schedule of benefits.	
Diagnostic and preventive care (type A services) Visits and images • Office visit during regular office hours for oral examination - limited to 2 visits every 12 months • Routine comprehensive or recall examination - limited to 2 visits every 12 months • Comprehensive periodontal evaluation - limited to 2 visits every 12 months • Problem focused examination - limited to 2 visits every 12 months • Detailed and extensive oral evaluation - problem focused, by report • Prophylaxis (cleaning)- limited to 2 treatments per year • Topical application of fluoride- limited to 2 courses of treatments per year • Topical application of fluoride varnish- limited to 2 treatments every 12 months • Sealants, per tooth- limited to 1 application every 3 years, for permanent molars only • Preventive resin restoration - limited to 1 application every 3 years for permanent molars only • Bitewing images - limited to 2 sets per year • Complete image series including bitewings if **medically necessary** - limited to 1 set every 3 years • Panoramic images- limited to 1 set every 3 years • Vertical bitewing images - limited to 2 sets per year • Periapical images • Cephalometric radiographic image • Oral/facial photographic images • Interpretation of diagnostic image • Intra-oral, occlusal view, maxillary or mandibular • Diagnostic models	

- Emergency palliative treatment per visit

Space maintainers

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Re-cementation of space maintainer
- Removal of space maintainer

Basic restorative care (type B services)

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation by other than the treating provider

Images and pathology

- Upper or lower jaw, extra-oral
- Therapeutic drug injection, by report

Oral surgery

- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Removal of residual tooth roots
  - Surgical removal of erupted tooth/root tip
  - Surgical access of an unerupted tooth
- Impacted teeth
  - Removal of tooth (soft tissue)
- Surgical removal of impacted teeth
  - Removal of partially bony tooth
  - Removal of completely bony tooth
  - Removal of tooth (completely bony with unusual surgical complications)
- Odontogenic cysts and neoplasms
- Other surgical procedures
  - Alveoplasty in conjunction with extractions - per quadrant
  - Alveoplasty in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty not in conjunction with extraction - per quadrant
  - Alveoplasty not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Excision of hyperplastic tissue
  - Excision of periocoronal gingiva
  - Removal of exostosis
  - Tooth reimplantation
  - Transplantation of tooth or tooth bud
  - Crown exposure to aid eruption
  - Frenectomy

- Suture of small wound, less than 5 cm

- Collection and application of autologous blood product - limited to 1 every 3 years

Periodontics

- Occlusal adjustment other than with an appliance or by restoration
- Root planing and scaling per quadrant - limited to 4 separate quadrants every 2 years
- Root planing and scaling (1 to 3 teeth per quadrant) - limited to once per site every 2 years
- Periodontal maintenance procedures following active therapy - limited to 4 in 12 months combined with adult prophylaxis after completion of active periodontal therapy
- Localized delivery of antimicrobial agents

Endodontics

- Pulp capping
- Pulpotomy
- Pulpal therapy
- Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp; does not include final restoration)

Restorative

- Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges - Multiple restorations in 1 surface will be considered as a single restoration
- Amalgam restorations
- Protective restoration
- Resin-based composite restorations other than for molars
- Pin retention per tooth in addition to amalgam or resin restoration
- Crowns when tooth cannot be restored with a filling material
  - Prefabricated stainless steel
  - Prefabricated resin crown excluding temporary crowns
- Recementation
  - Inlay
  - Crown
  - Fixed partial bridge

Prosthodontics

- Dentures and partials
  - Office reline
  - Laboratory relines
  - Special tissue conditioning per denture
  - Rebase, per denture
  - Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture

- Each tooth
- Each clasp

- Repairs to bridges, partial dentures

General anesthesia and intravenous sedation

- Only when **medically necessary** and only when provided in conjunction with a covered dental surgical procedure

Major restorative care (type C services)

Periodontics

- Osseous surgery including flap and closure, 1 to 3 teeth per quadrant - limited to 1 per site every 3 years
- Osseous surgery including flap and closure per quadrant - limited to 1 per quadrant every 3 years
- Soft tissue graft procedures
- Bone replacement graft, first site in quadrant - limited to 1 per quadrant every 3 years
- Gingivectomy per quadrant - limited to 1 per quadrant every 3 years
- Gingivectomy- 1 to 3 teeth per quadrant - limited to 1 per quadrant every 3 years
- Gingival flap procedure per quadrant - limited to 1 per quadrant every 3 years
- Gingival flap procedure , 1 to 3 teeth per quadrant - limited to 1 per site every 3 years
- Clinical crown lengthening
- Subepithelial connective tissue graft procedures including donor site surgery
- Full mouth debridement- limited to 1 treatment per lifetime

Endodontics

- Apexification/recalcification
- Apicoectomy
- Root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid
  - Molar
- Retreatment of previous root canal therapy:
  - Anterior
  - Bicuspid
  - Molar
- Root amputation
- Hemisection including any root removal

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as a treatment for decay or acute traumatic injury and only when the teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge
- Inlays/onlays - limited to 1 per tooth every 5 years
- Non-cosmetic veneers - limited to 1 per tooth every 5 years

- Crowns - limited to 1 per tooth every 5 years
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
  - Titanium
- Post and core
- Core build-up
- Repair Crowns, inlays, onlays, veneers
- Replace all teeth and acrylic on cast metal framework - maxillary/mandibular

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth that were not abutments to a denture or bridge less than 5 years old
- Replacement of existing bridges or dentures - limited to 1 every 5 years
- Bridge abutments (See inlays and crowns) per tooth - limited to 1 per tooth every 5 years
- Pontics - limited to 1 per tooth every 5 years
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
  - Removal bridge unilateral
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit including pontics - limited to 1 every 5 years
- Retainer: cast metal for resin bonded fixed prosthesis - limited to 1 every 5 years
- Retainer: porcelain/ceramic for resin bonded fixed prosthesis - limited to 1 every 5 years
- Dentures and partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture - limited to 1 every 5 years
- Complete lower denture - limited to 1 every 5 years
- Immediate upper denture - limited to 1 every 5 years
- Immediate lower denture - limited to 1 every 5 years
- Partial upper or lower resin base including any conventional clasps, rests and teeth - limited to 1

every 5 years

- Partial upper or lower cast metal base with resin saddles including any conventional clasps, rests and teeth - limited to 1 every 5 years
- Implants only if determined as a dental necessity - limited to 1 per tooth every 5 years
- Implant supported complete denture, partial denture - limited to 1 every 5 years
- Surgical placement pf interium implant body
- Surgical placement of transosteal implant
- Implant maintenance procedures
- Implant supported complete denture, partial denture
- Custom abutment - limited to 1 every 5 years
- Abutment supported retainer
- Bone graft at time of implant placement - limited to 1 every 5 years
- Repair implant prosthesis - limited to 1 every 5 years
- Repair implant abutment - limited to 1 every 5 years
- Replacement of semi-precision or precision attachment - limited to 1 every 5 years
- Debridement/osseous contouring of a peri-implant defect - limited to 1 every 5 years
- Implant removal - limited to 1 every 5 years
- Implant index - limited to 1 every 5 years
- Connecting bar
- Stress breakers
- Removable appliance therapy
- Fixed appliance therapy
- Interim partial denture (stayplate), anterior only
- Occlusal guard

Orthodontic services

- **Medically necessary** orthodontic treatment including removal of appliances, construction and placement of retainer
- Limited orthodontic treatment of the primary, transitional and adolescent dentition
- Interceptive orthodontic treatment of the primary, transitional dentition
- Comprehensive orthodontic treatment of the transitional and adolescent dentition
- Periodic orthodontic treatment visit as part of contract
- Pre-orthodontic treatment visit

Eligible health services	In-network coverage
6. Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder	$80 **copay physician** office 50% **copay specialist** office Covered based on the type of service and where it is received

Applied behavior analysis	$80 **copay physician** office 50% **copay specialist** office Covered based on the type of service and where it is received
Diabetic equipment, supplies and education	
Diabetic equipment	$80 **copay physician** office or **walk-in clinic** 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Diabetic supplies	$80 **copay physician** office or **walk-in clinic** 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Diabetic education	$80 **copay physician** office or **walk-in clinic** 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Family planning services - other	
Inpatient services	
Voluntary sterilization for males	50% **copay**
Abortion (termination of pregnancy)	50% **copay**
Outpatient services	
Voluntary sterilization for males	50% **copay**
Abortion (termination of pregnancy)	50% **copay**
Jaw joint disorder treatment	
Jaw joint disorder treatment	50% **copay**
Maternity and related newborn care	
Prenatal care services	
Inpatient and other maternity related services and supplies	50% **copay**
Other prenatal care services and supplies	$80 **copay physician** office 50% **copay specialist** office Covered based on the type of service and where it is received
Delivery services and postpartum care services	
Inpatient and newborn care services and supplies	50% **copay**
Performed in a facility or at a **physician** office	50% **copay**

Important note: Any cost share that is collected applies to the delivery and postpartum care services provided by an OB, GYN, or OB/GYN only. This cost share does not apply to prenatal care services provided by an OB, GYN, or OB/GYN.	
Mental health treatment Coverage provided under the same terms, conditions as any other illness.	
Inpatient mental health treatment Inpatient **residential treatment facility**	50% **copay**
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	50% **copay**
Outpatient mental health treatment visits to a **physician**, or **behavioral health provider** (includes **telemedicine** or **telehealth**)	50% **copay**
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	50% **copay**
Substance related disorders treatment Coverage provided under the same terms, conditions as any other illness.	
Inpatient **substance abuse detoxification** Inpatient **substance abuse** rehabilitation Inpatient **substance abuse** treatment in **residential treatment facility**	50% **copay**
Other inpatient **substance abuse detoxification** services and supplies Other inpatient **substance abuse** rehabilitation services and supplies Other inpatient **substance abuse residential treatment facility** services and supplies	50% **copay**
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider** (includes **telemedicine** or **telehealth**)	50% **copay**
Other outpatient **substance abuse** services or **partial hospitalization treatment** and **intensive outpatient program**	50% **copay**
Reconstructive breast surgery	
Reconstructive breast **surgery**	$80 **copay physician** office (non-surgical) 50% **copay specialist** office (non-surgical) 50% **copay physician** surgical services Covered based on the type of service and where it is received

Reconstructive surgery and supplies	
Reconstructive **surgery** and supplies	50% **copay physician** surgical services 50% **copay** h**ospital,** facilities other than outpatient **hospital** or in the office Covered based on the type of service and where it is received

Eligible health services	Network (IOE) facility	Network (Non-IOE facility)
Transplant services		
Inpatient and other inpatient services and supplies	50% **copay**	Coverage is limited to IOE only
Outpatient	Coverage is limited to IOE only	Coverage is limited to IOE only
Physician services	Coverage is limited to IOE only	Coverage is limited to IOE only

Eligible health services	In-network coverage
Treatment of basic infertility	
Basic infertility	$80 **copay**-**Physician** in the office (non-surgical) 50% **copay**-**Specialist** in the office (non-surgical) Covered based on the type of service and where it is received

Eligible health services	In-network coverage
7. Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
Performed at a facility	50% **copay**
Performed at **physician** office	50% **copay**
Performed at **specialist** office	50% **copay**
Diagnostic lab work	
Performed at a facility	50% **copay**
Performed at **physician** office	50% **copay**
Performed at **specialist** office	50% **copay**
Diagnostic radiological services	
Diagnostic radiological services (X-ray)	
Performed at a facility	50% **copay**
Performed at **physician** office	50% **copay**
Performed at **specialist** office	50% **copay**

Outpatient therapies	
Chemotherapy	
Chemotherapy	$80 **copay physician** office 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Outpatient infusion therapy	
Performed in a **physician** office or in a person's home	50% **copay**
Performed in outpatient facility	50% **copay**
Radiation therapy	
Radiation therapy	$80 **copay physician** office 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Specialty prescription drugs	
Performed in a **physician** office Performed in the outpatient department of a **hospital** Performed in an outpatient facility that is not a **hospital** or in the home	$80 **copay physician** office 50% **copay specialist** office 50% **copay hospital** or facilities other than outpatient **hospital** Covered based on the type of service and where it is received
Short-term cardiac and pulmonary rehabilitation services A visit is equal to no more than 1 hour of therapy.	
Cardiac and pulmonary rehabilitation	50% **copay**
Short-term rehabilitation therapy services A visit is equal to no more than 1 hour of therapy.	
Outpatient physical therapy	
Physical therapy	50% **copay**
Visit limit per year	Coverage is limited to 35 visits per year PT/OT/ST/Chiro are combined, separate from habilitation.
Outpatient occupational therapy	
Occupational therapy	50% **copay**
Visit limit per year	Coverage is limited to 35 visits per year PT/OT/ST/Chiro are combined, separate from habilitation.

Outpatient speech therapy	
Speech therapy	50% **copay**
Visit limit per year	Coverage is limited to 35 visits per year PT/OT/ST/Chiro are combined, separate from habilitation.
Spinal manipulation	
Spinal manipulation	50% **copay**
Visit limit per year	Coverage is limited to 35 visits per year PT/OT/ST/Chiro are combined, separate from habilitation.
Habilitation therapy services A visit is equal to no more than 1 hour of therapy.	
Physical, occupational, and speech therapies	50% **copay**
Visit limit per year	Coverage is limited to 35 visits per year PT/OT/ST/Chiro are combined, separate from rehabilitation.
Applied behavior analysis	
Applied behavior analysis	50% **copay**
Visit limit per year	None

Eligible health services	In-network coverage
8. Other services	
Acupuncture	
Acupuncture	Not covered
Alzheimer's disease	
Alzheimer's disease	$80 **copay physician** office 50% **copay specialist** office Covered based on the type of service and where it is received
Ambulance service	
Emergency ambulance	50% **copay**
Non-emergency ambulance	50% **copay**

Important note:

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

Clinical trial therapies (experimental or investigational)	
Clinical trial therapies (including routine patient costs)	$80 **copay physician** office 50% **copay specialist** office Covered based on the type of service and where it is received
Durable medical equipment (DME)	
DME	50% **copay**
Limit per year	None
Hearing aids	
Hearing aids	50% **copay**
Hearing aids limit	None
Cochlear implants and related services	
Cochlear implants and related services	50% **copay**
Replacement of cochlear implant external speech processor and controller components limit	Once every three years
Nutritional support	
Nutritional support	$80 **copay physician** office 50% **copay specialist** office Covered based on type of service and where it is received
Obesity (bariatric) surgery	
Obesity (bariatric) surgery	Not covered
Orthotic devices	
Orthotic devices	50% **copay**
Prosthetic devices	
Prosthetic devices	50% **copay**
Vision care	
Pediatric vision care **Coverage is limited to covered persons through the end of the month in which the person turns 19**	
Routine vision exams (including refraction)	
Performed by an ophthalmologist or optometrist	50% **copay**
Visit limit per year	Coverage is limited to 1 exam every 12 months age 0-19.
Vision care services and supplies	
Office visit for fitting of contact lenses	Not covered
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	50% **copay**
Number of eyeglass frames per year	One set of eyeglass frames
Number of **prescription** lenses per year	One pair of **prescription** lenses
Number of **prescription** contact lenses per year	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set

Adult vision care: Limited to covered person age 19 and over	
Routine vision exams (including refraction)	
Performed by an ophthalmologist or optometrist	50% **coinsurance**
Visit limit per year	Coverage is limited to 1 exam every 12 months.
Important note: Refer to the Vision care section in the certificate for the explanation of these vision care supplies. As to coverage for **prescription** lenses in a year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.	

9. Outpatient prescription drugs

Waiver for risk reducing breast cancer prescription drugs
The **prescription drug** 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%.
Waiver for contraceptives

The **prescription drug** cost share will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means they will be paid at 100% for:
• The following female contraceptives that are **generic prescription drugs**:
  − Oral drugs
  − Injectable drugs
  − Vaginal rings
  − Transdermal contraceptive patches
• Female contraceptive devices that are generic and brand-name devices
• FDA approved female:
  − Generic emergency contraceptives
  − Generic over-the-counter (OTC) emergency contraceptives
The **prescription drug** cost share will apply to **prescription drugs** that have a generic equivalent or biosimilar or generic alternative available within the same therapeutic drug class obtained at a **network pharmacy** unless you receive a medical exception. To the extent **generic prescription drugs** are not available, **brand-name prescription drugs** are covered. 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**.

Waiver for tobacco cessation prescription and over-the-counter drugs
The **prescription drug** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a **retail network pharmacy**. This means they will be paid at 100%. Your **prescription drug** cost share will apply after those two programs have been exhausted.

Eligible health services	In-network coverage
Per prescription cost share	
Tier 1 - preferred generic prescription drugs	
For each 30 day supply filled at a **retail pharmacy**	$20 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$50 **copay**
Tier 2 - preferred brand-name prescription drugs	
For each 30 day supply filled at a **retail pharmacy**	$65 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$162.50 **copay**
Tier 3 - non-preferred generic and brand-name prescription drugs	
For each 30 day supply filled at a **retail pharmacy**	$100 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$250 **copay**

Important note: Tier 1, 2 and 3 **specialty prescription drugs** are not eligible for fill at a **retail pharmacy** or **mail order pharmacy**.	
Tier 4 -- preferred specialty prescription drugs (including biosimilar prescription drugs)	
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	50% **copay** up to $500 per **prescription**
Tier 5 - non-preferred specialty prescription drugs(including biosimilar prescription drugs)	
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	50% **copay** up to $750 per **prescription**
Diabetic supplies and insulin	
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug in the schedule of benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	Paid according to the tier of drug in the schedule of benefits, above
Nutritional supports	
Nutritional supports	Paid according to the tier of drug per the schedule of benefits, above
Orally administered anti-cancer medications	
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	Paid according to the tier of drug in the schedule of benefits, above
Outpatient prescription contraceptive drugs and devices: includes oral and injectable drugs, vaginal rings and transdermal contraceptive patches	
Female contraceptives that are **generic** prescription drugs. For each 30 day supply	$0 per **prescription** or refill
Female contraceptives that are **brand name prescription drugs** For each 30 day supply	Paid according to the tier of drug in the schedule of benefits, above
Important note: Brand-name vaginal rings covered at 100% to the extent that a generic is not available.	
Female contraceptive generic devices and brand name devices. For each 30 day supply	Paid according to the tier of drug in the schedule of benefits, above
FDA-approved female generic and brand name emergency contraceptives. For each 30 day supply	Paid according to the tier of drug in the schedule of benefits, above
FDA-approved female generic and brand name over-the-counter emergency contraceptives. For each 30 day supply	Paid according to the tier of drug in the schedule of benefits, above
Preventive care drugs and supplements	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
Limitations: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, see the *How to contact us for help* section.	

Risk reducing breast cancer prescription drugs	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
Limitations: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **prescription drugs**, see the *How to contact us for help* section.	
Tobacco cessation prescription and over-the-counter drugs	
For each 30 day supply filled at a **retail pharmacy**	$0 per **prescription** or refill
Limitations: • Coverage is limited to two, 90-day treatment programs only. Any additional treatment programs will be paid according to the tier of drug per the schedule of benefits, above. • Coverage only includes generic drug when there is also a brand-name drug available. • Coverage is subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, see the *How to contact us for help* section.	
See the *Outpatient prescription drugs, Other services* section in your certificate, for more information on other **prescription drug** coverage under this plan.	
If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **generic prescription drug**.	

Form CCP Figure 1

TEXAS DEPARTMENT OF INSURANCE
REQUIRED DISCLOSURE NOTICE FOR ALL GROUP HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
DEDUCTIBLES - Section 11.506(2)(B), Subchapter F, Title 28, Texas Administrative Code: A deductible shall be for a specific dollar amount of the cost of the basic, limited, or single health care service. An HMO shall only charge a deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network	This plan includes deductibles. Please see the Evidence of coverage (EOC) for further information.	
COPAYMENTS -- Section 11.506(2)(A), Subchapter F, Title 28, Texas Administrative Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds 50%.	
TREATMENT BY A NON-PRIMARY CARE SPECIALIST AS A PCP – Sections 1271.201-203, Texas Insurance Code; Section 11.506(21), Subchapter F, Title 28, Texas Administrative Code: An EOC must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the HMO's medical director to use a nonprimary care physician specialist as the enrollee's PCP.		Not offered; not covered.
COVERAGE OF STAYS IN A CRISIS STABILIZATION UNIT FOR CHILDREN AND ADOLESCENTS – Sections §1355.051-058, Texas Insurance Code; Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code: If the plan covers treatment of mental/emotional illness/disorder while confined in a hospital, then the plan must also cover treatment in a residential treatment center for children and adolescents or a crisis stabilization unit. Coverage must be at least as favorable as that for treatment of mental/emotional illness/disorder in a hospital		Not offered; not covered.

AUTISM SPECTRUM DISORDER – Section 1355.015, Texas Insurance Code; Sections §21.4401-4404, Subchapter JJ, Title 28, Texas Administrative Code: A plan must provide coverage for screening a child for autism spectrum disorder at 18 and 24 months. A plan must cover treatment of autism spectrum disorder to an enrollee who is diagnosed with autism spectrum disorder from the date of diagnosis, only if the diagnosis was in place prior to the child's 10th birthday. The plan must cover all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's PCP in the treatment plan recommended by that PCP. The term "generally recognized services" may include: • Evaluation and assessment services • Applied behavior analysis • Behavior training and behavior management • Speech therapy; • Occupational therapy; • Physical therapy • Medications or nutritional supplements used to address symptoms of autism spectrum disorder. The plan is not required to provide coverage for benefits for an enrollee 10 years of age or older for applied behavior analysis for more than $36,000 per year.	Coverage includes autism screening for children behavioral assessments for children of all ages. **Autism spectrum disorder** Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan. **Important note:** Applied behavioral analysis requires preauthorization by Aetna. The network provider is responsible for obtaining preauthorization	

* Note: if additional space is needed, the carrier may add additional lines, or may continue the list on a subsequent page, but must clearly note that an additional page is attached.

**Pursuant to the Federal Patient Protection and Access to Care Act (PPACA), the following are covered at 100% with no copayments, deductibles or dollar maximum benefits:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Service Task Force (USPSTF);
- Routine Adult Physical Examinations (including immunizations, routine vision and hearing screenings);
- Routine Well Child Care (including immunizations);
- Routine Cancer Screenings (which include Screening Mammograms; Prostate Specific Antigen (PSA) Tests; Digital-Rectal Exams (DRE); Fecal Occult Blood Tests (FOBT); Sigmoidoscopies; Double Contrast Barium Enemas (DCBE) and Colonoscopies);
- Routine Eye Examinations, including refraction;
- Pediatric Preventive Dental; and
- Routine Gynecological Exams, including routine Pap smears.

This HMO Consumer Choice Health Benefit Plan may include requirements and/or restrictions on

deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other HMO plans. I understand that I may obtain additional information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

Signature of Applicant	
Name of Applicant	
Name of Business (if applicable)	
Address	
City / State / Zip	
Date	

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

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.

Important Information About Your Plan

Coverage of Applied Behavior Analysis
For the Treatment of Autism Spectrum Disorder

Your Plan includes coverage for the diagnosis and treatment of autism spectrum disorder. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder.

As part of this coverage, we will cover certain early intensive behavioral interventions, such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Applied behavioral analysis will be subject to the same cost sharing requirements as other, outpatient services provided by a behavioral health provider for the treatment of autism spectrum disorder.

Important notes:

For plans that did not include such coverage previously, applied behavior analysis for the treatment of autism spectrum disorder will be an eligible health service for all new and renewing policies or plans with an effective date on or after January 1, 2017.

Applied behavior analysis requires precertification by Aetna.

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