Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-312-3862.

Smartphone or Tablet

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

Non-Discrimination

Banner|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.

Banner|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 1-877-312-3862.

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

Civil Rights Coordinator
P.O. Box 14462, Lexington, KY 40512
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).

Language Assistance

TTY: 711

To access language services at no cost to you, call 1-877-312-3862. (English)

Para acceder a los servicios de idiomas sin costo, llame al 877-312-3862. (Spanish)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 877-312-3862. (Navajo)

如欲使用免費語言服務，請致電 877-312-3862。(Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 877-312-3862. (Vietnamese)

Click here to enter text. للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرق877-312-3862.
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Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 877-312-3862. (Tagalog)

무료 언어 서비스를 이용하려면 877-312-3862 번으로 전화해 주십시오. (Korean)

Afin d'accéder aux services langagiers sans frais, composez le 877-312-3862. (French)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 877-312-3862 an. (German)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 877-312-3862. (Russian)

言語サービスを無料でご利用いただくには、877-312-3862 までお電話ください。
(Japanese)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 877-312-3862 تماس بگیرید. (Persian-Farsi)

ܒܝ ܫܒܩܐ ܟܠ ܒܝܠܓܐ ܕܝܢ ܐܝ ܟܠ ܡܕܒܪܢܘܬܐ ܕܠܫܢܐ ܕܚܝܢ ܠܐ ܡܫܠܡ ܐܢ ܐܬ ܠܟ، ܩܒܠ ܠܡܣܦܪ ܗܕܐ: 877-312-3862
(Syriac-Assyrian)

Za besplatne prevodilačke usluge pozovite 877-312-3862. (Serbo-Croatian)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 877-312-3862 (Thai)

Banner Health and Aetna Health Insurance Company

Preferred Provider Organization (PPO) Medical Plan

Booklet-Certificate

AZ Banner OA Managed Plus Gold 1000 80/50
AZM0010010118871

Underwritten by Banner Health and Aetna Health Insurance Company in the state of Arizona

Welcome

Thank you for choosing **Banner|Aetna**.

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Banner|Aetna** plan for in-network and out-of-network coverage.

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

The third document is the group policy between **Banner Health and Aetna Health Insurance Company** (**Banner|Aetna**) and your **policyholder**. Ask your employer if you have any questions about the group policy.

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 **Banner|Aetna** 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 **Banner|Aetna** plan.

Table of Contents

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 booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents, if dependent coverage is available under your plan.
- When we say "us", "we", and "our", we mean **Banner|Aetna**.
- 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 in-network

Your in-network 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**.

You will pay less cost share when you use a **network provider**.

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 exclusions* section. (We will refer to this section as the "*Exclusions*" section in the rest of this booklet-certificate.)
- 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 Aetna Navigator® secure member website at www.banneraetna.com

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

Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

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

3. **Paying for eligible health services– the general requirements**
There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:
- The **eligible health service** is **medically necessary**.
- You get the **eligible health service** from a **network provider**.
- You or your **provider precertifies** the **eligible health service** when required.

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

4. **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.

5. **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 "external review organization" or ERO for short, may sometimes make the final decision for us.

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

How your plan works while you are covered out-of-network

You have coverage when you want to get your care from **providers** who are not part of the **Banner|Aetna** network. It's called out-of-network coverage.

Your out-of-network coverage:

- Means you may have to pay for services at the time they are provided. You may be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section
- **Out-of-network providers** and any exceptions in the *Who provides the care* section
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits
- Claim information in 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 Aetna Navigator® secure member website at www.banneraetna.com.
- Register for our secure Internet access to reliable health information, tools and resources. Aetna Navigator® 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 **Banner|Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Banner|Aetna**, 4500 East Cotton Center Blvd. Phoenix, AZ 85040

Your member ID card

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

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

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna Navigator® secure member website at www.banneraetna.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 your plan 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 eligibility 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 support order or court-order (whether or not the child resides with you)
  - Grandchildren in your court-ordered custody

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 **policyholder** 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 your plan 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 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 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 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 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 your plan 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 added a dependent because of marriage, birth, adoption or foster care. See the *Adding new dependents* section for more information.
- 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 spouse, domestic 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 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 and precertification 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 *Exclusions* 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**.
- For in-network coverage, you get the **eligible health service** from a **network provider**.
- You or your **provider precertifies** the **eligible health service** when required.

This section addresses the **medical necessity** and **precertification** requirements. You will find the requirement to use a **network provider** and any exceptions 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**.

Precertification

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

In-network: Your **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. For precertification of outpatient **prescription drugs**, see ***Eligible health services*** *under your plan – Outpatient prescription drugs – What precertification requirements apply*. If your **physician** or **PCP** doesn't get a required **precertification**, 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 **precertification**. If your **physician** or **PCP** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important note – when you pay all* section.

Out-of-network: When you go to an **out-of-network provider**, you are responsible to obtain **precertification** from us for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay. See your schedule of benefits for this information. The list of services and supplies that require **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied, see the schedule of benefits *Precertification benefit reduction* section.

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

	You, your **physician** or the facility will:
For non-emergency admissions	Call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission	Call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**, the diagnosis of an **illness**, or an **injury**.
For outpatient non-emergency medical services requiring **precertification**	Call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will tell you and your **physician** in writing of the **precertification** decision, where required by state law. If your **precertified** services are approved, the approval is valid for 180 days as long as you remain enrolled in the plan.

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

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

What if you don't obtain the required precertification?

If you don't obtain the required **precertification**:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification benefit reduction* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses you have will not count toward your out-of-network **deductible** or **maximum out-of-pocket limit** if there are any.

What types of services require precertification?
Precertification is required for the following types of services and supplies:

Inpatient services and supplies	**Outpatient services and supplies**
Stays in a **hospital**	Complex imaging
Stays in a **skilled nursing facility**	**Cosmetic** and reconstructive **surgery**
Stays in a rehabilitation facility	Non-emergency transportation by fixed wing airplane
Stays in a **hospice facility**	Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications)
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**	Kidney dialysis
Bariatric (obesity) **surgery**	Outpatient back **surgery** not performed in a **physician's** office
	Private duty nursing services
	Sleep studies
	Knee **surgery**
	Transcranial magnetic stimulation (TMS)Wrist **surgery**
	Psychological testing\neuropsychological testing
	Applied behavior analysis
	Intensive outpatient program (IOP) – mental disorder and **substance abuse** diagnoses
	Outpatient **detoxification**
	Partial hospitalization treatment – mental disorder and **substance abuse** diagnoses

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 *Exclusions* 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 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**, and it includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
    - Screening and counseling services on topics such as:
        - Interpersonal and domestic violence
        - Sexually transmitted diseases
        - Human Immune Deficiency Virus (HIV) infections
    - Screening for gestational diabetes for women
    - High risk Human Papillomavirus (HPV) DNA testing for women
- 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 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
  - A single baseline mammogram if you are age 35-39
  - Once per plan year if you are age 40 and older
- 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

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 *Exclusions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (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 – female 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**

Important note:
Your plan covers **telemedicine** only when you get your consult through a **provider** that has contracted with **Banner | Aetna** to offer these services.

All in-person office visits covered with a **behavioral health provider** are also covered if you use **telemedicine** instead.

Telemedicine may have different cost sharing. 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 and/or private duty nursing when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.
- Dialysis care outpatient and inpatient

Anesthesia and hospital charges for dental care

Eligible health services include anesthesia and hospitalization for dental or oral surgery if you have a hazardous medical condition. Hazardous medical conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia).

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.

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.

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:

- You are homebound.
- Your **physician** orders them.
- 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 or occupational therapy.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

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

Short-term physical, speech and occupational therapy 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
- 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 or occupational therapist, social worker or family counselor
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

Skilled nursing facility

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

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

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

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.

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**.

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 to 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 and precertification requirements* section for more information. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and **ambulance** assistance. If possible, call your **physician**, 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 *Exclusions* and *Glossary* sections for specific information.

In case of an urgent condition

Urgent condition

If you need care for an **urgent condition**, 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**.

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 *Exclusions* 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 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 a **Banner | Aetna** 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 **precertification** by **Banner | Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for obtaining **precertification** if you are using an **out-of-network provider**.

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
  - Foot orthotics
- Equipment
  - 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 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)
- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)

Maternity and related newborn care

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

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

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

If you have adopted a child or a child has been placed with you for adoption, the costs of the child's birth will be considered eligible health services if all of these conditions are met:

- You adopt the child within one year of their birth
- You are required to pay the costs of their birth
- You let us know within 60 days that you have been approved to adopt

If the child's natural mother has maternity coverage of her own, you will need to let us know. Her plan will need to process the claim before we do.

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies related to your condition provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility**, including:
    - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
    - Other outpatient mental health treatment such as:
        - **Partial hospitalization treatment** provided in a facility or program for mental health treatment provided under the direction of a **physician**
        - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
- Electro-convulsive therapy (ECT)
- Mental health injectables
- Transcranial magnetic stimulation (TMS)
- 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** 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:
      - You are homebound
      - Your **physician** orders them

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

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.
- Your **surgery** corrects an accidental **injury**. The **surgery** must be performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected. **Surgery and related dental services** to fix teeth injured due to an accident 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 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 **precertify** 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
- A non-**IOE facility**

Eligible health services also include corneal (corneal graft with amniotic membrane) transplants. Corneal transplants are not available at **IOE facilities**.

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

Travel and lodging expenses

Eligible health services include travel and lodging expenses for you and your companion to travel between your home and the **IOE facility** if you live 60 or more miles from the IOE facility, such as:

- Coach class round-trip air
- Train
- Bus travel
- Car travel, including a rental while at the transplant site
- Lodging costs
- Food

Once your transplant service has been **precertified**, you can be reimbursed for your transplant travel and lodging expenses during any of these phases:

- Evaluation
- Candidacy
- Transplant
- Post-transplant care

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
- Extended CT scale (ECT) and Brain electrical activity mapping (BEAM) imaging

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.

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

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 booklet-certificate

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 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:
  - 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:
  - 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.

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**.

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.
- We determine 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 an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network services, coverage is limited to benefits for routine patient services provided within the network.

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 **precertify** 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.
- Compression garments for treatment of lymphedema

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 *Exclusions* 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 a hearing aid

Nutritional evaluations

Eligible health services include nutritional evaluation and counseling when adjusting the diet may be beneficial for a diagnosed chronic disease or condition, including but not limited to:

- **Morbid obesity**
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

Nutritional support including medical foods to treat inherited metabolic disorders and formulas to treat eosinophilic gastrointestinal disorders

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

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 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.

Obesity (bariatric) surgery

Eligible health services include the treatment of **morbid obesity** and include bariatric **surgical procedures** and related outpatient services

Prosthetic devices

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

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** This includes ostomy supplies.

Coverage includes:

- 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
- Wigs and hairpieces for alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns

Spinal manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

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. The vision eyewear coverage is automatically available only from network vision locations. When making your appointment, confirm your **provider** is a network vision location for pediatric vision services. If it is not a network vision location, you will have to pay for the eyewear and submit a claim form for reimbursement. 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
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses

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

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**
- How to access out-of-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 **precertification** 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.

How to access out-of-network pharmacies

You can directly access an out-of-network **pharmacy** to get covered outpatient **prescription drugs**. If you use an out-of-network **pharmacy** to obtain outpatient **prescription drugs**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network outpatient **prescription drug deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims

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 *Exclusions* 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 and precertification 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 number on your ID card or log on to your Aetna Navigator® secure member website at www.banneraetna.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**.

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 **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

For females who are able to become pregnant, 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.

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**.

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 **precertification**, **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.

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 Aetna Navigator® secure member website at www.banneraetna.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. 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/coinsurance**.

Where your schedule of benefits fits in

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

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

- The type of **prescription** 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 precertification requirements apply

Why do some drugs need precertification?
For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**precertification**". The requirement for getting approval in advance guides appropriate use of 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 **precertification** 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 medical 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 health care services are denied through **precertification** 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 medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a **non-preferred drug**. You, someone who represents you or your **prescriber** may submit a request for a quicker review for an urgent situation by:

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

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

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will tell you, someone who represents you or your **prescriber** of the coverage determination of the external review no later than 72 hours after we receive your request. If the medical exception is approved, coverage will be provided for the entire time of the **prescription**. For quicker medical exceptions in urgent situations, we will tell you, someone who represents you or your **prescriber** of the coverage determination no later than 24 hours after we receive your request. If the quicker medical exception is approved, coverage will be provided for the entire time you have an urgent situation.

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.

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 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 exclusions that apply to your plan.

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

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 certificate or by a rider or amendment included with this certificate:

Acupuncture, **acupressure and acupuncture therapy**, except where described in the *Eligible health services under your plan* section.

Ambulance services

- **Ambulance** services, for routine transportation to receive outpatient or inpatient services
- Non-emergency 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 device that would perform the function of a body organ

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

Examples of these are:

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

For autologous blood donations, only administration and processing expenses are covered.

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 **Banner | 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. This exclusion does not apply to hospice counseling services by a social worker or family counselor for individual and family 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 This exclusion does not apply to court-ordered mental health and substance abuse treatment.

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 except as covered under Eligible health services under your plan, Autism Spectrum Disorder

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
- 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 – female contraceptives counseling, devices and voluntary sterilization

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Contraception services during a **stay** in a **hospital** or other facility for medical care
- Male contraceptive methods, sterilization procedures or devices

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), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies(except for devices and supplies related to diabetes)

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

when there is no underlying medical condition that hinders the child's growth

Hearing aids
The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken.
- Replacement parts or repairs for a hearing aid.
- Batteries or cords (except those for cochlear implants).
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss.
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist.

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**.
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

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.

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. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - 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

Nutritional support including medical foods to treat inherited metabolic disorders and formulas to treat eosinophilic gastrointestinal disorders

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

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 – Other services* section and the *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, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, and open adjustable gastric banding
  - 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

Other primary payer

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

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 medical exception is approved
    - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical 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 **Banner|Aetna '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 **precertification** 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**
    - **Prescription drugs** used primarily for the treatment of **infertility** except where stated in the *Eligible health services under your plan – Treatment of infertility* section
- 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**:
  - 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

- The services of any other **physician** who helps the operating **physician**.
- 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 policy
- 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
  - Removal of bony impacted teeth
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Dental implants

  This exclusion does not include 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

- The services of any other **physician** who helps the operating **physician**.
- 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.

Outpatient 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
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

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 certificate.

Sexual dysfunction and enhancement

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

Strength and performance

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

Telemedicine

- Services given by **providers** that are not contracted with **Banner|Aetna** as **telemedicine providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls 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 certificate:

- 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 plan – Treatment of infertility – Basic infertility* section. 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

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- 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
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your **stay** in a **hospital** or other facility for health care
- 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** and **out-of-network providers**.

Network providers

We have contracted with **providers** 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

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

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

Your PCP

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

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

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

How do you choose your PCP?

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

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

What will your PCP do for you?

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

Your **PCP** can also:

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

How do I change my PCP?

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

Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **eligible health services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification** when required

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 **Banner|Aetna** 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	**When your provider stops participation with Banner|Aetna**
Request for approval	You need to complete a Transition of Coverage Request form and send it to us. Call Member Services at the number on the back of your ID card to get the form.	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 **Banner|Aetna**.

	If you are a new enrollee and your provider is not contracted with Banner|Aetna
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 number on your ID card.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.
How claim is paid	Your claim will be paid at the **network provider** cost sharing level.

If you are pregnant and in your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

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

What the plan pays and what you pay

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

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

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

The general rule

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**:

- You pay for the entire expense up to any **deductible** limit, when a **deductible** applies.

And then

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

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**, and **recognized charge** for an **out-of-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 and precertification requirements* section.
- When your plan requires **precertification**, it was requested, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* 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 **deductible** or towards your **maximum out-of-pocket limit**.

Special financial responsibility

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

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

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 **deductibles**, **copayments** and **coinsurance**.

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

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).	• You must send us notice and proof as soon as reasonably possible. • If you are unable to complete a claim form, you must send us: – A description of services – Bill of charges – Any medical documentation you received from your **provider**
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.	• You must send us notice and proof as soon as reasonably possible.
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 after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of claims and communicating our claim decisions

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

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

Urgent care claim
An urgent 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 **precertify** them.

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

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

The chart below shows the different types of claims 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	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial decision by us	36 hours	15 days	30 days	24 hours for urgent request*, or 72 hours if clinical information is required and received more than 24 hours after request** 15 days for non-urgent request
Extensions	Not applicable	15 days	15 days	
If we request more information	36 hours	15 days	30 days	
Time you have to send us additional information	48 hours	45 days	45 days	

*****We have to receive the request at least 24 hours before the previously approved health care services end.

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized charge** with an **out-of-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 benefit determination" or "adverse decision". It is also an "adverse benefit determination" if we rescind your coverage entirely.

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

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call the number on your ID card or write us. See the *How to contact us for help* section. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

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

Appeals of adverse benefit determinations

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

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

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

Another person may submit an appeal for you, including a **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 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.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

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

Timeframes for deciding an appeal

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.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (us)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of appeals process

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

- Contact the Arizona Department of Insurance to request an investigation of a complaint or appeal.
- File a complaint or appeal with the Arizona Department of Insurance.
- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

Sometimes you do not have to complete the two level 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 external review process.
- We did not follow all of the claim determination and appeal requirements of the State or Federal Department of Health and Human Services. But, you will not be able to proceed directly to external 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.

External review

External review is a review done by people in an organization outside of **Banner|Aetna**. This is called an external review organization (ERO). Sometimes, this is called an independent review organization (IRO).

You have a right to external 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 external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Banner|Aetna**
- Within 120 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Banner|Aetna**. We are responsible for the cost of sending this information to the ERO and the cost of the external review.

Banner|Aetna will contact the ERO that will conduct the review of your claim.

- Send required information, which includes the material you sent us, to the Arizona Department of Insurance within 5 business days from the date we received the notice of your request for an external review

The Arizona Department of Insurance will:

- Send the information to an independent ERO within 5 business days from the date they receive the request for **medical necessity** reviews, or
- Review required information, or send to an independent review organization if necessary, within 15 business days from the date they receive the request for coverage or claim denial reviews
- Once a decision has been made, send notification of the decision to you and to **Banner|Aetna** within 5 business days from the date they receive the decision

When reviewing the information you sent, the Arizona Department of Insurance or the ERO will:

- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse determination

Your **provider** tells us that a delay in your receiving health care services would:

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

For final adverse determination

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

When we receive a request for this faster review, we will let you and your **provider** know within one business day that the request was received. We will send the request and all the required information to the director to start the process. If your situation qualifies for this faster review, you will receive a decision within 72 hours of the external reviewer getting your request.

Recordkeeping

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

Fees and expenses

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the ERO to **Banner|Aetna.** We are responsible for the cost of sending this information to the ERO and the cost of the external review.

Coordination of benefits

Some people have health coverage under more than one health 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).

Key terms

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

Allowable expense means:

- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic** surgery generally is not an allowable expense under this plan.

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

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

Here's how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.

We will never pay an amount that, when combined with payments from your other coverage, adds up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. A plan that does not contain a COB provision is always the primary plan.

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. See the *How to contact us for help* section if you have questions.	

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

COBRA or state continuation	The plan covering you as an employee or retiree, or the dependent of an employee or retiree, is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree, or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense.
Benefit reserve each family member has a separate benefit reserve for each **calendar year**	The benefit reserve: • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

How COB works with Medicare

This section explains how the benefits under this plan work with benefits available under Medicare.

When we say Medicare, we mean the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you meet the criteria for coverage because of:

- Your age
- A disability
- End stage renal disease (ESRD)

You are also eligible for Medicare even if you are not enrolled because you:

- Refused it
- Dropped it
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid if you were covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is Primary	We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B **deductible** will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

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.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

- The group policy ends
- This plan is discontinued
- You voluntarily stop your coverage
- You are no longer eligible for coverage
- Your employment ends
- You do not make the required contributions
- We end your coverage
- You become covered under another medical plan offered by your employer

Your employer will mail you a notice 60 days before your coverage ends. The notice will tell you why your coverage is ending.

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 contribution toward the cost of dependent coverage
- Your coverage ends for any of the reasons listed above
- You enroll under a group Medicare plan that we offer and your coverage ends under that plan

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil union partners.
- The date the domestic partnership ends. For a domestic partnership, you should provide your employer a completed and signed Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

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

Why would we end coverage?

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

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 form 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 coverage under the plan as long as the **policyholder** and we agree to do so and as described below: • Your coverage may continue until stopped by the **policyholder** but not beyond 24 months from the start of the absence.

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

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 **Banner|Aetna**	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 **Banner|Aetna**	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 **Banner|Aetna**	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 **Banner|Aetna**	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 for other reasons

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

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 (more than 50% of income) 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 policy 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 booklet-certificate

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

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.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments or riders too. Under certain circumstances, we or your employer or the law may change your plan. 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 certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible health services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Legal action

You must 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 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 rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to a **Banner|Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

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.

Your health information

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

Glossary

Banner|Aetna
Banner Health and Aetna Health Insurance Company, an affiliate or a third party vendor under contract with **Banner|Aetna**.

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

Behavioral health provider
An individual professional or facility 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.

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

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.

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

Deductible
For plans that include a **deductible**, this is the amount you pay for **eligible health services** per year before your plan starts to pay as listed in the schedule of benefits.

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.banneraetna.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 **Banner|Aetna** 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 established by **Banner|Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Banner|Aetna** or an affiliate. A copy of the **drug guide** is available at your request. Or you can find it on the **Banner|Aetna** website at www.banneraetna.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 booklet-certificate 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 *Exclusions* 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 danger to the health of an unborn child

Emergency services
Treatment given in a **hospital's** emergency room 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.

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 **Banner | Aetna** in the **provider directory** as an Institutes of Excellence **network provider** for specific services or procedures.

Intensive outpatient program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day. 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**, **coinsurance** and any **deductible**, 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.

*For **prescription drug** services from a **network pharmacy**:*
The amount we established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts we agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include 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 **Banner|Aetna**, 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.**

Partial hospitalization treatment
Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. 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 and chiropractors . Under some plans, a physician can also be a **primary care physician (PCP)**.

Policyholder
An employer or organization who agrees to remit the **premiums** for coverage under the group policy payable to **Banner|Aetna**. The **policyholder** shall act only as an agent of **Banner|Aetna members** in the employer group, and shall not be the agent of **Banner|Aetna** for any purpose.

Precertification, precertify
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 **Banner|Aetna** 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**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician

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.

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the **recognized charge** for specific services or supplies:

Service or supply	**Recognized charge**
Professional services and other services or supplies not mentioned below	90% of the Medicare allowed rate
Services of **hospitals** and other facilities	90% of the Medicare allowed rate
Prescription drugs	50% of the average wholesale price (AWP)
Dental expenses	80% of the prevailing charge rate
Important note: if the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Recognized charge does not apply to involuntary services.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Banner|Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

- Involuntary services are services or supplies that are one of the following:
  - Performed at a **network** facility by an **out-of-network provider,** unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
  - For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
  - For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
  - For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or related to, the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits:
We have online tools to help decide whether to get care and, if so, where. Use the "Estimate the Cost of Care" tool on Aetna Navigator®. **Banner|Aetna's** secure member website at www.banneraetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

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. **Referrals** only apply to in-network coverage.

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 **Banner|Aetna** 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 **Banner | Aetna** 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, **Banner | Aetna** will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable 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 **Banner|Aetna** as a network **pharmacy** to fill **prescriptions** for **specialty prescription drugs**.

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

Step therapy
A form of **precertification** 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 **Banner|Aetna** or an affiliate. 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 **Banner|Aetna** website at www.banneraetna.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 most recent version of 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

Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Telephone calls, except for behavioral health services
- Any other method required by state law

Terminal illness

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

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 a **Banner|Aetna** member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment**, **deductible** or **coinsurance** amounts
- 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.

Confidentiality Notice

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

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

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

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

Additional Information Provided by

Your Employer

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

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

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

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

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

Continue Group Health Plan Coverage
Note: This sub-section applies to the Plan if your Employer employs 20 or more employees in accordance with a formula mandated by federal law. Check with your Employer to determine if COBRA continuation applies to the Plan.

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

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

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.

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

Note: This sub-section applies to the Plan if your Employer employs 50 or more employees as determined by a formula defined by federal law. Check with your Employer to determine if FMLA applies to the Plan.

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

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

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

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

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

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

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

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

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

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

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

Banner Health and Aetna Health Insurance Company

Preferred Provider Organization (PPO)
Medical Plan
Schedule of benefits

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group, this may not apply. Please contact the policyholder for additional information.

Underwritten by Banner Health and Aetna Health Insurance Company in the state of Arizona

Schedule of benefits

This schedule of benefits lists the **deductibles**, **copayments** or **coinsurance**, 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 **deductibles**, **copayments** or **coinsurance**, 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. They may be:
  combined limits between
  separate limits for

in-network **providers** and **out-of-network providers** unless we say differently.

Important note:
All **covered benefits** are subject to the **calendar year deductible**, **out-of-pocket maximum**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits below.

As you read this *Schedule of benefits*, you will sometimes see "Covered based on type of service and where it is received" instead of a specific **copayment** or **coinsurance**. This means that your **copayment** or **coinsurance** will vary, depending on who provides the service to you and where you receive the service.

Example 1: When you receive *Allergy testing and treatment* services in a **specialist's** office, then you will pay the applicable **copayment** listed in the S*pecialist office visits* section.

Example 2: When you receive *Reconstructive breast surgery* services in an outpatient setting, then you will pay the applicable **coinsurance** listed in the *Outpatient surgery* section. However, if you receive these services while inpatient in a **hospital**, then you will pay the applicable *Hospital care* **coinsurance**.

How your deductible works

This schedule of benefits shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **eligible health services**. You will continue to pay **copayments** or **coinsurance**, if any, for **eligible health services** after you meet your **deductible**.

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.banneraetna.com
- Call the phone number on your ID card

Banner Health and Aetna Health Insurance Company's group policy provides the coverage described in this schedule of benefits**.** This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

Plan features	Deductible/maximums	
	In-network coverage	**Out-of-network coverage**
Deductible		
You have to meet your **deductible** before this plan pays for benefits.		
Individual	$1,000 per year	$5,000 per year
Family	$2,000 per year	$10,000 per year
Deductible waiver		
The in-network **deductible** is waived for all of the following **eligible health services**: • Preventive care and wellness • Family planning services - female contraceptives • Nutritional support The out of network **deductible** is waived for all the following **eligible health services**: • Nutritional support		

Maximum out-of-pocket limit		
Individual	$6,000 per year	$24,000 per year
Family	$12,000 per year	$48,000 per year
Precertification covered benefit reduction		
Your booklet-certificate contains a complete description of the pre-approval program. You will find details on pre-approval in the *Medical necessity and precertification requirements* section. If you don't get pre-approval of your eligible health services when required, this plan will reduce by $400 per occurrence what we will pay for each type of eligible health service. You may have to pay the additional amount of the recognized charge because you didn't get pre-approval. This amount is not a covered benefit and does not apply to your **deductible** or your maximum out-of-pocket limit, if any.		

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions
The **deductible** may not apply to certain eligible health services. You must pay any applicable cost share for eligible health services to which the **deductible** does not apply.
Individual **deductible** You pay for eligible health services each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. Once you have reached the **deductible**, this plan will begin to pay for eligible health services for the rest of the year.
Family **deductible** You pay for network eligible health services each year before the plan begins to pay. After the amount paid for eligible health services reaches your family **deductible**, this plan will begin to pay for **eligible health services** for the rest of the year.
To satisfy this family **deductible** for the rest of the year, the combined **eligible health services** that you and each of your covered dependents incur towards the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductible**s for you and your covered dependents are met for the rest of the year.
Deductible credit
If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

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.
Eligible health services applied to the in-network **maximum out-of-pocket limit** apply only to the in-network **maximum out-of-pocket limit**. **Eligible health services** applied to the out-of-network **maximum out-of-pocket limit** apply only to the out-of-network **maximum out-of-pocket limit**.
This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
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 eligible 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 eligible 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

The 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**

Limit provisions

Eligible health services will apply to the in-network limit and the out-of-network limit.

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 booklet-certificate.

Eligible health services	In-network coverage	Out-of-network coverage
1. Preventive care and wellness		
Preventive care and wellness	0%, no **deductible** applies	50% after **deductible**

- **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 –** Female contraceptive counseling services office visit, devices, voluntary sterilization

Preventive care and wellness benefit limitations

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 30 and older limited to one every 36 months

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**.

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.

Preventive screening and counseling services: Limitations are per 12 months unless stated below:

Obesity and/or healthy diet	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
Misuse of alcohol and/or drugs	Limited to 5 visits every 12 months
Use of tobacco products	Limited to 8 visits every 12 months
Sexually transmitted infection	Limited to 2 visits every 12 months
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

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 of your booklet-certificate. 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 booklet-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	Out-of-network coverage
2. Physicians and other health professionals		
Physician services		
Office hours visits (non-surgical) non preventive care	$20 **copay,** no **deductible** applies	50% after **deductible**
Telemedicine consultation by a **physician**	Covered based on type of service and where it is received	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,** no **deductible** applies	50% after **deductible**
Telemedicine		
Telemedicine consultation by a **specialist**	Covered based on type of service and where it is received	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	20% after **deductible**	50% after **deductible**
Allergy testing and treatment		
Performed at a **physician** or **specialist** office	Covered based on type of service and where it is received	50% after **deductible**
Immunizations when not part of the physical exam		
Immunizations when not part of the physical exam	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Medical injectables		
Performed at a **physician** or **specialist** office	20% after **deductible**	50% after **deductible**
Physician surgical services		
Inpatient surgical services	20% after **deductible**	50% after **deductible**
Performed at a **physician** or **specialist** office	20% after **deductible**	50% after **deductible**
Alternatives to physician office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit	$20 **copay,** no **deductible** applies	50% after **deductible**
Preventive care immunizations	0%, no **deductible** applies	50% after **deductible**
Individual screening and counseling services at a walk-in clinic Includes obesity and/or healthy diet counseling, use of tobacco products		
Individual screening and counseling services	0%, no **deductible** applies	50% after **deductible**
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	Out-of-network coverage
3. Hospital and other facility care		
Hospital care		
Inpatient **hospital**	20% after **deductible**	50% after **deductible**
Alternatives to hospital stays		
Outpatient surgery		
Performed in **hospital** outpatient department	30% after **deductible**	50% after **deductible**
Performed in facility other than **hospital** outpatient department	20% after **deductible**	50% after **deductible**
Physician services	Covered based on type of service and where it is received	50% after **deductible**
Home health care		
Outpatient	20% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 42 visits per year network and out-of-network combined	
Hospice care		
Inpatient services	20% after **deductible**	50% after **deductible**
Outpatient services	20% after **deductible**	50% after **deductible**
Skilled nursing facility		
Inpatient facility	20% after **deductible**	50% after **deductible**
Day limit per year	Coverage is limited to 90 days per year network and out-of-network combined	

Eligible health services	In-network coverage	Out-of-network coverage
4. Emergency services and urgent care A separate **hospital** emergency room or urgent care cost share will apply for each visit to an emergency room or an **urgent care provider**.		
Hospital emergency room	20% after **deductible**	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	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 (**deductible**, **copayment**, **coinsurance**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. • You should send the bill to the address listed on 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.		
Urgent medical care at a free standing facility that is not a **hospital**	$50 **copay,** no **deductible** applies	50% after **deductible**
Non-urgent use of **urgent care provider** at a free standing facility that is not a **hospital**	Not covered	Not covered

Eligible health services	In-network coverage	Out-of-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% after **deductible**	30% after **deductible**
Type B services	30% after **deductible**	50% after **deductible**
Type C services	50% after **deductible**	50% after **deductible**
Orthodontic services	50% after **deductible**	50% after **deductible**
Dental emergency maximum benefit: For covered dental care services provided for a dental emergency by an **out-of-network dental provider**, the plan pays a benefit at the in-network level of coverage up to the dental emergency maximum of $75. Any charges above the emergency maximum are covered at the out-of-network level of benefits.		
Dental benefits are subject to the plan's **deductible** and **maximum out-of-pocket limit**, if any and as explained in this schedule of benefits.		
Diagnostic and preventive care (type A services) Visits and images • D0120: Office visit during regular office hours, for oral examination (limited to: 2 visits every 12 months) • D0140: Problem-focused examination (limited to: 2 visits every 12 months) • D0145: Oral evaluation – child under 3 (limited to: 2 visits every 12 months) • D0150: Comprehensive oral evaluation (limited to: 2 visits every 12 months) • D0160: Detailed and extensive oral examination – problem focused • D0180: Comprehensive periodontal evaluation (limited to: 2 visits every 12 months) • D0210: Complete image series, including bitewings (limited to: 1 set every 3 years) • D0220: Periapical 1st image • D0240: Intra-oral, occlusal radiographic image • Bitewing images (limited to: 2 sets per 12 months) – D0270: one image – D0272: two images – D0273: three images – D0274: four images • D0277: Vertical bitewing images (limited to: 2 sets per year) • D0330: Panoramic images (limited to: 1 set every 3 years) • D0340: Cephalometric image • D0350: 2D oral/facial photographic images • D0391: Interpretation of diagnostic image • D0470: Diagnostic models • D1110: Prophylaxis (cleaning) - adult (limited to: 2 treatments per year) • D1120: Prophylaxis (cleaning) – child (limited to: 2 treatments per year) • D1206: Topical fluoride varnish (limited to: 2 courses every 12 months) • D1208: Topical application of fluoride (limited to: 2 courses every 12 months) • D1351: Sealants, per tooth (limited to: one application every 3 years for permanent molars) • D1352: Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (limited to: one application every 3 years for permanent molars) • D1353: Sealant repair, per tooth • D2990: Resin infiltration of lesion (limited to: 1 per tooth every 3 years)		

- D9110: Emergency palliative treatment per visit

Space maintainers (includes all adjustments within 6 months after installation)

- D1510, D1515: Fixed (unilateral or bilateral)
- D1520, D1525: Removable (unilateral or bilateral)
- D1550: Re-cementation of space maintainer
- D1555: Removal of space maintainer

Basic restorative care (type B services)

Visits and images

- D9310: Consultation (by other than the treating provider)
- D9440: Professional visit after hours (payment will be made on the basis of services rendered or the charge for the after-hours visit, whichever is greater)
- D9930: Treatment of complications (post surgical) unusual circumstance, by report

Images, pathology, drugs

- D0250: Extra-oral first 2D projection radiographic image
- D0251: Extra-oral posterior dental radiographic image
- D9610: Therapeutic drug injection, by report

Oral surgery

- D7111: Extraction, coronal remnants – deciduous tooth
- D7140: Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- D7210: Surgical removal of erupted tooth requiring removal of bone and/or resectioning of tooth
- D7251: Coronectomy
- D7250: Surgical removal of residual tooth roots
- D7230: Surgical removal of impacted teeth – partial bony
- D7220: Removal of impacted tooth (soft tissue)
- D7230: Removal of impacted tooth (partially bony)
- D7240: Removal of impacted tooth (completely bony)
- D7241: Removal of impacted tooth (completely bony with unusual surgical complications)
- D7260: Closure of oral fistula of maxillary sinus
- D7270: Tooth reimplantation
- D7272: Tooth transplantation
- D7280: Surgical access of an unerupted tooth
- D7283: Crown exposure to aid eruption
- D7510: Incision and drainage of abscess
- D7310: Alveoplasty, in conjunction with extractions – four or more teeth, per quadrant
- D7311: Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- D7320: Alveoplasty, not in conjunction with extraction - per quadrant
- D7321: Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces, per quadrant
- D7471: Removal of exostosis
- D7472: Removal of torus palatinus
- D7473: Removal of torus mandibularis
- D7910: Suture of soft tissue injury wound less than 5 cm
- D7953: Bone replacement graft for ridge preservation – per site

- D7960: Frenectomy
- D7970: Excision of hyperplastic tissue
- D7971: Excision of pericornal gingiva

Periodontics

- D4341: Periodontal scaling and root planing, per quadrant – 4 or more teeth (limited to 4 separate quadrants every 2 years)
- D4342: Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per quadrant every 2 years)
- D4910: Periodontal maintenance procedures following active therapy (limited to 4 in 12 months, combined with prophylaxis after completion of active periodontal therapy)
- D7921: Collection and application of autologous blood concentrate product (limited to 1 in 36 months)
- D9951: Occlusal adjustment – limited
- D9952: Occlusal adjustment - complete

Endodontics

- D3110: Pulp capping – direct
- D3120: Pulp capping - indirect
- D3220: Pulpotomy (therapeutic)
- D3222: Partial pulpotomy of apexogensis
- D3230: Pulpal therapy – anterior primary tooth
- D3240: Pulpal therapy – posterior primary tooth
- D3355, D3356, D3357: Pulpal regeneration
- D3430: Retrograde filling

Restorative dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration)

- D2140: Amalgam restorations – 1 surface
- D2150: Amalgam restorations – 2 surface
- D2160: Amalgam restorations – 3 surface
- D2161: Amalgam restorations – 4 or more surface
- D2330: Resin-based composite restorations – 1 surface anterior
- D2331: Resin-based composite restorations – 2 surface anterior
- D2332: Resin-based composite restorations – 3 surface anterior
- D2335: Resin-based composite restorations – 4 or more surfaces or involving incisal angel (anterior)
- D2390: Resin-based composite crown, anterior
- D2391: Resin-based composite – 1 surface posterior
- D2392: Resin-based composite – 2 surfaces posterior
- D2393: Resin-based composite – 3 surfaces posterior
- D2394: Resin-based composite – 4 or more surfaces posterior

Pins:

- D2951: Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)

- D2930: Prefabricated stainless steel – primary teeth
- D2931: Prefabricated stainless steel – permanent teeth
- D2932: Prefabricated resin crown (excluding temporary crowns)
- D2940: Protective resin
- D2941: Interim therapeutic restoration – primary teeth
- D2929: Prefabricated porcelain/ceramic crown – primary teeth

Recementation:

- D2910: Inlay
- D2915: Fabricated – prefabricated post and core
- D2920: Crown
- D6092: Implant/abutment supported crown
- D6093: Implant/abutment supported fixed partial denture
- D6930: Fixed partial denture retainers

Prosthodontics

Dentures and partials

- D5410: Adjustment to complete denture – upper (adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
- D5411: Adjustment to complete denture – lower (adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
- D5421: Adjustment to partial denture – upper (adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)
- D5422: Adjustment to partial denture – lower (adjustments made within 6 months after installation, by the same dentist who installed it, are inclusive to the denture)

  Repairs:
  - D5511: Repair broken complete denture base, mandibular
  - D5512: Repair broken complete denture base, maxillary
  - D5520: Replace missing or broken tooth – complete denture
  - D5611: Repair resin partial denture base, mandibular
  - D5612: Repair resin partial denture base, maxillary
  - D5621: Repair cast framework, mandibular
  - D5622: Repair cast framework, maxillary
  - D5630: Broken clasp, per tooth (partial denture)
  - D5640: Replace broken tooth – per tooth (partial denture)
  - D5650: Add tooth to existing partial denture
  - D5660: Add clasp to existing partial denture – per tooth
  - D5670: Replace all teeth and acrylic on cast metal framework – upper partial denture
  - D5671: Replace all teeth and acrylic on cast metal framework – lower partial denture
- D5850: Special tissue conditioning, per denture – upper
- D5851: Special tissue conditioning, per denture – lower
- D5710: Rebase, complete upper denture
- D5711: Rebase, complete lower denture
- D5720: Rebase upper partial denture
- D5721: Rebase lower partial denture
- D5730: Reline complete upper denture (chairside)
- D5731: Reline complete lower denture (chairside)

- D5740: Reline upper partial denture (chairside)
- D5741: reline lower partial denture (chairside)
- D5750: Reline complete upper denture (laboratory)
- D5751: Reline complete lower denture (laboratory)
- D5760: Reline upper partial denture (laboratory)
- D5761: Reline lower partial denture (laboratory)
- D6980: Fixed partial denture repair necessitated by material failure

General anesthesia and intravenous sedation

- D9219: Evaluation – general anesthesia/deep sedation
- D9222: Deep sedation/general anesthesia – first 15 minutes
- D9223: General anesthesia/deep sedation – each 15 minute increments
- D9239: Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes
- D9243: Intravenous Conscious sedation-each 15 minute increment

Major restorative care (type C services)

Periodontics

- D4210: Gingivectomy or gingivoplasty, per quadrant (limited to 1 per quadrant every 3 years)
- D4211: Gingivectomy or gingivoplasty, 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- D4212: Gingivectomy or gingivoplasty, to allow access for restorative procedure, per tooth (limited to 1 per quadrant every 3 years)
- D4240: Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- D4241: Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per quadrant every 3 years)
- D4249: Clinical crown lengthening
- D4260: Osseous surgery, four or more contiguous teeth (limited to 1 per quadrant every 3 years)
- D4261: Osseous surgery, including flap and closure, 1 to 3 contiguous teeth per quadrant (limited to 1 per site every 3 years)
- D4263: Bone replacement graft, first site in quadrant (limited to 1 every 3 years)
- D4270: Pedical soft tissue graft procedure
- D4273: Autogenous subepithelial connective tissue graft procedures
- D4275: Non-autogenous connective soft tissue allograft
- D4277: free soft tissue graft procedure 1st tooth, implant or edentulous tooth position in graft
- D4278: free soft tissue graft procedure each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4283: Autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285: Non-autogenous connective tissue graft procedure – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4355: Full mouth debridement (limited to 1 treatment per lifetime)

Endodontics

- Root canal therapy including medically necessary images:
  - D3310: Anterior
  - D3320: Bicuspid
  - D3330: Molar

- Retreatment of previous root canal therapy including medically necessary images:
  - D3346: Anterior
  - D3347: Bicuspid
  - D3348: Molar
- D3351: Apexification/recalcification – initial visit
- D3352: Apexification/recalcification – interim medication replacement
- D3353: Apexification/recalcification – final visit
- D3355: Pulpal regeneration – initial visit
- D3356: Interium medications replacement
- D3357: Completion of treatment
- D3410: Apicoectomy – anterior
- D3421: Apicoectomy – bicuspid
- D3425: Apicoectomy – molar
- D3426: Apicoectomy – each additional tooth
- D3450: Root amputation
- D3920: 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 teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 5 years)

- D2510: Inlay – metallic, 1 surface (limited to 1 tooth every 5 years)
- D2520: Inlay – metallic, 2 surface (limited to 1 tooth every 5 years)
- D2530: Inlay – metallic, 3 or more surface (limited to 1 tooth every 5 years)
- D2542: Onlay – metallic, 2 surface (limited to 1 tooth every 5 years)
- D2543: Onlay – metallic, 3 surface (limited to 1 tooth every 5 years)
- D2544: Onlay – metallic, 4 or more surface (limited to 1 tooth every 5 years)
- D2610: Inlay – porcelain/ceramic – 1 surface (limited to 1 tooth every 5 years)
- D2620: Inlay – porcelain/ceramic – 2 surface (limited to 1 tooth every 5 years)
- D2630: Inlay – porcelain/ceramic – 3 or more surface (limited to 1 tooth every 5 years)
- D2642: Onlay – porcelain/ceramic – 2 surface (limited to 1 tooth every 5 years)
- D2643: Onlay – porcelain/ceramic – 3 surface (limited to 1 tooth every 5 years)
- D2644: Onlay – porcelain/ceramic – in addition to inlay (limited to 1 tooth every 5 years)
- D2650: Inlay – composite/resin – 1 surface (limited to 1 tooth every 5 years)
- D2651: Inlay – composite/resin – 2 surface (limited to 1 tooth every 5 years)
- D2652: Inlay – composite/resin – 3 surface (limited to 1 tooth every 5 years)
- D2662: Onlay – composite/resin – 2 surface (limited to 1 tooth every 5 years)
- D2663: Onlay – composite/resin – 3 surface (limited to 1 tooth every 5 years)
- D2664: Onlay – composite/resin – 4 or more surface (limited to 1 tooth every 5 years)
- Crowns (limited to 1 tooth every 5 years)
  - D2710: Resin
  - D2720: Resin with high noble metal
  - D2721: Resin with base metal
  - D2722: Resin with noble metal
  - D2740: Porcelain/ceramic substrate
  - D2750: Porcelain with high noble metal
  - D2751: Porcelain with base metal

  - D2752: Porcelain with noble metal
  - D2780: ¾ cast high noble metal
  - D2781: ¾ cast predominantly base metal
  - D2782: ¾ cast noble metal
  - D2783: ¾ porcelain/ceramic
  - D2790: Full cast high noble metal
  - D2791: Full cast base metal
  - D2792: Full cast noble metal
  - D2794: Titanium
- D2950: Core build-up
- D2952: Post and core
- D2953: Each additional post
- D2954: Prefabricated post and core
- D2957: Each additional prefabricated post
- D2960: Labial veneer (resin) – chairside
- D2961: Labial veneer (resin laminate) – laboratory (limited to 1 tooth every 5 years)
- D2963: Labial veneer (porcelain) – laboratory (limited to 1 tooth every 5 years)
- Repairs:
  - D2980: Crown repair
  - D2981: Inlay repair
  - D2982: Onlay repair
  - D2983: Veneer repair

Prosthodontics

Dentures and partial dentures: (Replacement of existing dentures or partial dentures/bridges) (limited to 1 every 5 years)

- D5110: Complete upper denture (limited to 1 every 5 years)
- D5120: Complete lower denture (limited to 1 every 5 years)
- D5130: Immediate upper denture (limited to 1 every 5 years)
- D5140: Immediate lower denture (limited to 1 every 5 years)
- D5211: Partial upper resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5212: Partial lower resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5213: Partial upper cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5214: Partial lower cast metal base with resin saddles (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5221: Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5222: Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)
- D5223: Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) Includes limited follow-up care only; does not include future rebasing (limited to 1 every 5 years)
- D5224: Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) (limited to 1 every 5 years)

- D5820: Interium partial denture, upper
- D5821: Interium partial denture, lower
- D5281: Removable partial denture (unilateral) (limited to 1 every 5 years)
- Implant services:
  - D6010: Surgical placement of implant: endosteal (limited to 1 every 5 years)
  - D6012: Surgical placement of interium implant body (limited to 1 every 5 years)
  - D6040: Surgical placement of eposteal implant (limited to 1 every 5 years)
  - D6050: Transosteal implant, including hardware (limited to 1 every 5 years)
  - D6055: Connecting bar – implant or abutment supported (limited to 1 every 5 years)
  - D6056: Prefabricated abutment (limited to 1 every 5 years)
  - D6057: Custom fabricated abutment (limited to 1 every 5 years)
  - D6058: Abutment supported porcelain/ceramic crown (limited to 1 every 5 years)
  - D6059: Abutment supported porcelain fused to high noble metal (limited to 1 every 5 years)
  - D6060: Abutment supported porcelain fused to predominately base metal crown (limited to 1 every 5 years)
  - D6061: Abutment supported porcelain fused to noble metal crown (limited to 1 every 5 years)
  - D6062: Abutment supported cast high noble metal crown (limited to 1 every 5 years)
  - D6063: Abutment supported cast predominately base metal crown (limited to 1 every 5 years)
  - D6064: Abutment supported cast noble metal crown (limited to 1 every 5 years)
  - D6065: Implant supported porcelain/ceramic crown (limited to 1 every 5 years)
  - D6066: Implant supported porcelain fused to high noble metal (titanium) (limited to 1 every 5 years)
  - D6067: Implant supported metal crown (titanium) (limited to 1 every 5 years)
  - D6068: Abutment supported retainer for porcelain/ceramic fixed partial denture (limited to 1 every 5 years)
  - D6069: Abutment supported retainer for porcelain fused to high noble metal fixed partial denture (limited to 1 every 5 years)
  - D6070: Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture (limited to 1 every 5 years)
  - D6071: Abutment supported retainer for porcelain fused to noble metal fixed partial denture
  - D6072: Abutment supported retainer for cast high noble metal fixed partial denture (limited to 1 every 5 years)
  - D6073: Abutment supported retainer for predominately base metal fixed partial denture (limited to 1 every 5 years)
  - D6074: Abutment supported retainer for cast noble metal fixed partial denture (limited to 1 every 5 years)
  - D6075: Implant supported retainer for ceramic fixed partial denture (limited to 1 every 5 years)
  - D6076: Implant supported retainer for porcelain fused to high noble metal fixed partial denture (limited to 1 every 5 years)
  - D6077: Implant supported retainer for cast metal fixed partial denture (limited to 1 every 5 years)
  - D6080: Implant maintenance procedures (limited to 1 every 5 years)
  - D6090: Repair implant prosthesis (limited to 1 every 5 years)
  - D6091: Replacement of semi-precious or precision attachment (limited to 1 every 5 years)
  - D6094: Abutment supported crown titanium (limited to 1 every 5 years)
  - D6095: Repair implant abutment (limited to 1 every 5 years)
  - D6096: Remove broken implant retaining screw
  - D6100: Implant removal, by report (limited to 1 every 5 years)

- D6101: Debridement of a periimplant defect or defects surrounding a single implant (limited to 1 every 5 years)
- D6102: Debridement and osseous contouring of a periimplant defect or defects surrounding a single implant (limited to 1 every 5 years)
- D6103: Bone graft for repair of periimplant defect (limited to 1 every 5 years)
- D6104: Bone graft at time of implant placement (limited to 1 every 5 years)
- D6110: Implant/abutment supported removable denture, upper (limited to 1 every 5 years)
- D6111: Implant/abutment supported removable denture, lower (limited to 1 every 5 years)
- D6112: Implant/abutment supported removable denture for partially edentulous arch, upper (limited to 1 every 5 years)
- D6113: Implant/abutment supported removable denture for partially edentulous arch, lower (limited to 1 every 5 years)
- D6114: Implant/abutment supported fixed denture for completely edentulous arch, upper (limited to 1 every 5 years)
- D6115: Implant/abutment supported fixed denture for completely edentulous arch, lower (limited to 1 every 5 years)
- D6116: Implant/abutment supported fixed denture for partially edentulous arch, upper (limited to 1 every 5 years)
- D6117: Implant/abutment supported fixed denture for partially edentulous arch, lower (limited to 1 every 5 years)
- D6119: Implant/abutment supported interim fixed denture for edentulous arch – maxillary
- D6190: Implant index (limited to 1 every 5 years)

- Pontics –fixed partial denture
  - D6210: Cast high noble metal (limited to 1 every 5 years)
  - D6211: Cast base metal (limited to 1 every 5 years)
  - D6212: Cast noble metal (limited to 1 every 5 years)
  - D6214: Titanium (limited to 1 every 5 years)
  - D6240: Porcelain fused to high noble metal (limited to 1 every 5 years)
  - D6241: Porcelain to base metal (limited to 1 every 5 years)
  - D6242: Porcelain fused to noble metal (limited to 1 every 5 years)
  - D6245: Porcelain/ceramic (limited to 1 every 5 years)
  - D6250: Resin with high noble metal (limited to 1 every 5 years)
  - D6251: Resin with predominately base metal (limited to 1 every 5 years)
  - D6252: Resin with noble metal (limited to 1 every 5 years)
- Inlays/onlays – fixed partial denture :
  - D6545: Retainer cast metal for resin bonded fixed prosthesis (limited to 1 every 5 years)
  - D6548: Retainer porcelain/ceramic for resin bonded fixed prosthesis (limited to 1 every 5 years)
  - D6600: Retainer inlay-porcelain/ceramic (limited to 1 every 5 years)
  - D6608: Retainer onlay-porcelain/ceramic (limited to 1 every 5 years)
  - D6602: Retainer inlay-cast high noble metal, two surfaces (limited to 1 every 5 years)
  - D6604: Retainer inlay-cast predominately base metal, two surfaces (limited to 1 every 5 years)
  - D6606: Retainer inlay-cast noble metal, two surfaces (limited to 1 every 5 years)
  - D6603: Retainer inlay-cast high noble metal, three or more surfaces (limited to 1 every 5 years)
  - D6605: Retainer inlay-cast predominately base metal, three or more surfaces (limited to 1 every 5 years)
  - D6607: Retainer inlay-cast noble metal, three or more surfaces (limited to 1 every 5 years)
  - D6611: Retainer onlay-cast high noble metal, three or more surfaces (limited to 1 every 5 years)

- D6613: Retainer onlay-cast predominately base metal, three or more surfaces (limited to 1 every 5 years)
- D6615: Retainer onlay-cast noble metal, three or more surfaces (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. Specialized techniques and characterizations are not eligible.)
- Crowns-fixed partial dentures:
  - D6740: retainer crown – porcelain/ceramic (limited to 1 every 5 years)
  - D6750: retainer crown – porcelain fused to high noble metal (limited to 1 every 5 years)
  - D6751: retainer crown – porcelain fused to predominately base metal (limited to 1 every 5 years)
  - D6752: retainer crown – porcelain fused to noble metal (limited to 1 every 5 years)
  - D6780: retainer crown – ¾ cast high noble metal (limited to 1 every 5 years)
  - D6781: retainer crown – ¾ cast predominately base metal (limited to 1 every 5 years)
  - D6782: retainer crown – ¾ cast noble metal (limited to 1 every 5 years)
  - D6783: retainer crown – ¾ porcelain/ceramic (limited to 1 every 5 years)
  - D6790: retainer crown – full cast high noble metal (limited to 1 every 5 years)
  - D6791: retainer crown – full cast predominately base metal (limited to 1 every 5 years)
  - D6792: retainer crown - full cast noble metal (limited to 1 every 5 years)
- D6940: Stress breakers
- D6985: Pediatric partial denture (limited to 1 every 5 years)
- D8210: Removable appliance therapy
- D8220: Fixed or cemented appliance therapy
- D9932: Cleaning and inspection of removable complete denture, upper
- D9933: Cleaning and inspection of removable complete partial denture, lower
- D9934: Cleaning and inspection of removable complete partial denture, upper
- D9935: Cleaning and inspection of removable complete denture, lower
- D9940: Occlusal guard, patients age 13 older
- D9943: Occlusal guard adjustment (Not eligible within first 6 months after placement of appliance)

Orthodontic services

- Medically necessary orthodontic treatment (includes removal of appliances and construction of retainer)
  - D8010: Limited orthodontic treatment of the primary dentition
  - D8020: Limited orthodontic treatment of the transitional dentition
  - D8030: Limited orthodontic treatment of the adolescent dentition
  - D8050: Interceptive orthodontic treatment of the primary dentition
  - D8060: Interceptive orthodontic treatment of the transitional dentition
  - D8070: Comprehensive orthodontic treatment of the transitional dentition
  - D8080: Comprehensive orthodontic treatment of the adolescent dentition
  - D8090: Comprehensive treatment of adult dentition
  - D8660: Pre-orthodontic treatment examination to monitor growth and development
  - D8670: Periodic orthodontic treatment visit (as part of contract)
  - D8680: Orthodontic retention (removal of appliances, construction and placement of retainer(s)
  - D8691: Repair of orthodontic appliance
  - D8693: Rebonding or recementing; and/or repair, as required of fixed retainers
  - D8694: Repair of fixed retainers

Eligible health services	In-network coverage	Out-of-network coverage
6. Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Applied behavior analysis	20% after **deductible**	50% after **deductible**
Diabetic equipment, supplies and education		
Diabetic equipment	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Diabetic supplies	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Diabetic education	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Family planning services - other		
Inpatient services		
Voluntary sterilization for males	20% after **deductible**	50% after **deductible**
Abortion (termination of pregnancy)	20% after **deductible**	50% after **deductible**
Outpatient services		
Voluntary sterilization for males	Covered based on type of service and where it is received	50% after **deductible**
Abortion (termination of pregnancy)	Covered based on type of service and where it is received	50% after **deductible**
Jaw joint disorder treatment		
Jaw joint disorder treatment	Covered based on type of service and where it is received	50% after **deductible**
Maternity and related newborn care		
Prenatal care services		
Inpatient and other maternity related services and supplies	20% after **deductible**	50% after **deductible**
Other prenatal care services and supplies	Covered based on the type of service and where it is received	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	20% after **deductible**	50% after **deductible**
Performed in a facility or at a **physician** office	20% after **deductible**	50% after **deductible**
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**	20% after **deductible**	50% after **deductible**
Other inpatient mental health treatment services and supplies Other inpatient **residential treatment facility** services and supplies	20% after **deductible**	50% after **deductible**
Outpatient mental health treatment visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	$50 **copay,** no **deductible** applies	50% after **deductible**
Other outpatient mental health treatment or skilled behavioral health services in the home, **partial hospitalization treatment** and **intensive outpatient program**	20% after **deductible**	50% after **deductible**
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**	20% after **deductible**	50% after **deductible**
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	20% after **deductible**	50% after **deductible**
Outpatient **substance abuse** visits to a **physician** or **behavioral health provider** (includes **telemedicine**)	$50 **copay,** no **deductible** applies	50% after **deductible**

Other outpatient **substance abuse** services or **partial hospitalization treatment** and **intensive outpatient program**	20% after **deductible**	50% after **deductible**
Important note: • **Partial hospitalization treatment** is at least 4 hours, but less than 24 hours per day of clinical treatment provided in a facility or program for treatment of **substance abuse**. Treatment is provided under the direction of a **physician**. • **Intensive outpatient program** is at least 2 hours per day and at least 6 hours per week of clinical treatment provided in a facility or program for treatment of **substance abuse**. Treatment is provided under the direction of a **physician**.		
Reconstructive breast surgery		
Reconstructive breast **surgery**	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Reconstructive surgery and supplies		
Reconstructive **surgery** and supplies	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility) and out-of-network coverage**
Transplant services		
Inpatient and other inpatient services and supplies	20% after **deductible**	50% after **deductible**
Outpatient	Coverage limited to IOE only	50% after **deductible**
Physician services	Coverage limited to IOE only	50% after **deductible**

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of basic infertility		
Basic **infertility**	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Eligible health services	**In-network coverage**	**Out-of-network coverage**
7. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed at a facility	20% after **deductible**	50% after **deductible**
Performed at **physician** office	20% after **deductible**	50% after **deductible**
Performed at **specialist** office	20% after **deductible**	50% after **deductible**
Diagnostic lab work		
Performed at a facility	20% after **deductible**	50% after **deductible**
Performed at **physician** office	Included in office visit **copay**	50% after **deductible**
Performed at **specialist** office	Included in office visit **copay**	50% after **deductible**
Diagnostic radiological services (X-ray)		
Performed at a facility	20% after **deductible**	50% after **deductible**
Performed at **physician** office	Included in office visit **copay**	50% after **deductible**
Performed at **specialist** office	Included in office visit **copay**	50% after **deductible**
Outpatient therapies		
Chemotherapy		
Chemotherapy	Covered based on the type of service and where it is received	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	20% after **deductible**	50% after **deductible**
Performed in outpatient facility	20% after **deductible**	50% after **deductible**
Radiation therapy		
Radiation therapy	Covered based on the type of service and where it is received	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	Covered based on the type of service and where it is received	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	20% after **deductible**	50% after **deductible**
Short-term rehabilitation therapy services A visit is equal to no more than 1 hour of therapy.		
Outpatient physical therapy		
Physical therapy	20% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 60 visits per year PT/OT/ST combined, rehabilitation & habilitation separate network and out-of-network combined	
Outpatient occupational therapy		
Occupational therapy	20% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 60 visits per year PT/OT/ST combined, rehabilitation & habilitation separate network and out-of-network combined	
Outpatient speech therapy		
Speech therapy	20% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 60 visits per year PT/OT/ST combined, rehabilitation & habilitation separate network and out-of-network combined	
Habilitation therapy services A visit is equal to no more than 1 hour of therapy.		
Physical, occupational, and speech therapies	20% after **deductible**	50% after **deductible**
Visit limit per year	Coverage is limited to 60 visits per year PT/OT/ST combined, rehabilitation & habilitation separate network and out-of-network combined	

Eligible health services	In-network coverage	Out-of-network coverage
8. Other services		
Ambulance service		
Emergency **ambulance**	20% after **deductible**	Covered same as in-network
Non-emergency **ambulance**	20% after **deductible**	Covered same as in-network
Clinical trial therapies (experimental or investigational)		
Clinical trial therapies (including routine patient costs)	Covered based on the type of service and where it is received	Covered based on the type of service and where it is received
Durable medical equipment (DME)		
DME	50% after **deductible**	50% after **deductible**
Limit per year	None	
Hearing aids		
Hearing aids	50% after **deductible**	50% after **deductible**
Hearing aids limit	Coverage is limited to 1 per ear per year.	
Nutritional support		
Nutritional support	20%, no **deductible** applies	50%, no **deductible** applies

Obesity (bariatric) surgery		
Obesity (bariatric) surgery	20% after **deductible**	50% after **deductible**
Prosthetic devices		
Prosthetic devices	50% after **deductible**	50% after **deductible**
Spinal manipulation		
Spinal manipulation	$50 **copay,** no **deductible** applies	50% after **deductible**
Visit limit per year	None	
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% after **deductible**	50% after **deductible**
Visit limit	Coverage is limited to 1 exam every 12 months age 0-19 network and out-of-network combined	
Vision care services and supplies		
Office visit for fitting of contact lenses	50% after **deductible**	50% after **deductible**
Preferred or non-preferred Eyeglass frames, **prescription** lenses or **prescription** contact lenses	50% after **deductible**	50% after **deductible**
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 (includes non-conventional	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	

9. Outpatient prescription drugs

Deductible waiver

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	Out-of-network coverage
Per prescription cost share		
Tier 1 - preferred generic prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$15 **copay**	$15 **copay** then 30%
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$37.50 **copay**	$37.50 **copay** then 30%
Tier 2 - preferred brand-name prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$50 **copay**	$50 **copay** then 30%
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$125 **copay**	$125 **copay** then 30%
Tier 3 - non-preferred generic and brand-name prescription drugs		
For each 30 day supply filled at a **retail pharmacy**	$80 **copay**	$80 **copay** then 30%

For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$200 **copay**	$200 **copay** then 30%
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**	30% up to $300 per **prescription**	30% up to $300 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% up to $500 per **prescription**	50% up to $500 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	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 **mail order pharmacy**	Paid according to the tier of drug in the schedule of benefits, above	Paid according to the tier of drug in 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	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	$15 **copay** then 30%
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	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	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	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	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	Paid according to the tier of drug in the schedule of benefits, above
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	Paid according to the tier of drug in the schedule of benefits, above
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	Paid according to the tier of drug in the schedule of benefits, above
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.		
Important note: See the *Outpatient prescription drugs, Other services* section for more information on other **prescription drug** coverage under this plan.		
If you or your **prescriber** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the cost share that applies to **brand-name prescription drugs**.		