



151 Farmington
Ave
Hartford, CT,
06156

Re: Group Number 0175537

We're sending you an electronic file with your plan documents

Thank you for doing business with Aetna. Enclosed are your plan documents. Here are a couple of other things to keep in mind as you review this material.

For your employees

Members can always find their benefit information on their member website. They can go to [Aetna.com](https://www.aetna.com) to log in or register. They may also contact us for a free paper copy.

We offer free aids and services for anyone with disabilities. If a member needs these services, have them call the number on their member ID card.

Have questions?

Contact your plan representative or account manager for help.

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AETNA HEALTH OF CALIFORNIA INC.

Group agreement

The HMO group agreement is by and between

**AETNA HEALTH OF CALIFORNIA INC. and
THE WATERFRONT BEACH RESORT**
Contract holder

Group agreement number: 0175537
Effective date: September 01, 2025
Contract situs: California

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

Term of the HMO group agreement:

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

Premium due dates: The **effective date** and the 1st day of each month after that

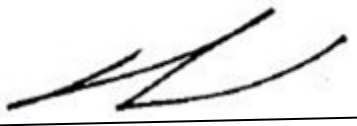
You can renew this group agreement each year ("guaranteed renewable"). We decide the **premium** rates. However, we may decide not to renew the group agreement under certain conditions, which are explained in this group agreement, or when required by law. See the *Termination* section for more information.

You may keep this group agreement in force by meeting the group agreement requirements and by paying the **premium** on time. See the *Premium* section for more information

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

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

By:



Edward C. Lee.
Vice President and Secretary

Table of contents

	Page
The HMO group agreement.....	3
If you want to discuss your coverage	3
Definitions	4
Premium	5
Fees for special services and assessments	7
Some of our other responsibilities	9
Some of your other requirements and responsibilities	9
Termination	13
Intentional deception	15
Responsibility for conduct	15
General provisions.....	16

The HMO group agreement

The HMO group agreement consists of the following documents:

- Your group application (Any statement made in the absence of fraud is deemed a representation not a warranty)
- This group agreement
- The evidence(s) of coverage (EOC)
- The schedule of benefits
- Riders and amendments

If you want to discuss your coverage

If you have questions about your coverage under the group agreement, or if you wish to discuss it, contact your agent. If you have additional questions, you may contact us at:

AETNA HEALTH OF CALIFORNIA INC.

1385 East Shaw Ave
Fresno, CA 93710
1-800-445-5299

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

Definitions

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

Contract holder

THE WATERFRONT BEACH RESORT and entities associated with it for purpose of coverage under this group agreement.

Covered person

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

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

Effective date

Date your coverage begins under this group agreement.

Premium due date

The **effective date** and the 1st day of each month after that.

Renewal date

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

Termination date

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

Premium

Premium – rates and amount due

The premium rates will be on record with you and us. You will receive a new rate sheet when the premium rates change. Any rate sheet will state its **effective date**.

We charge premium based on the premium rates in effect on the **premium due date**.

The premium due on any **premium due date** is the total of the premium charges for your coverage.

When we calculate premium due, we will use our records to determine who is a **covered person**.

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

Premium – individual proration

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

Premiums shall be adjusted as outlined below for persons whose:

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

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

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

Premium – changes in rates

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

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

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

We will let you know in writing of any change in premium rate 120 days before they take effect.

Premium – experience credit

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

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

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

As a condition of us giving you an experience credit, we can require you to share it, in an agreed upon manner. We will require you to apply at least the excess experience credit for the sole benefit of the employees, if the sum of employee contributions for coverage exceeds the premium paid, less any experience credits.

Premium – when due

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

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

Premium – how billed and paid

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

We may accept a partial payment but this does not waive our right to collect the entire amount due. We may choose not to accept **premium** that is paid for you by someone else unless we are required to by law.

Premium – overdue amounts

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

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

Premium – eligibility corrections

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

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

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

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

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

Premium – waiver

Payment of premiums

We may waive up to 1 month's billed premium payments during any group agreement term.

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

Repayment of the waived premium

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

Fees for special services and assessments

Special services

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

The special services are:

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

Special services – fees

We may change any fee not already agreed to and included in your premium with 120 days advance notice to you.

Payment for third party technology provider

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

Assessments

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

Fees and assessments – when due

Fees and assessments are due on the **premium due date** upon invoice.

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

Fees and assessments – how billed and paid

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

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

Fees and assessments – overdue amounts

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

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

Some of our other responsibilities

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

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

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

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

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

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

You shall distribute two documents required by the federal ACA:

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

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

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

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

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

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

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

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

Distribution – EOC and schedule of benefits

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

Information – access

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

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

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

Information – enrollment

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

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

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

We can and will rely on the information that you send and that it is correct.

You shall:

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

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

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

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

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

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

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

90 day waiting period limitation

Your plan can't have a waiting period of more than 90 days. That means employees and their dependents must be able to begin health coverage within 90 days. This is a requirement of the ACA. It applies both to you and to us.

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

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

Notices – termination of coverage

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

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

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

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

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

Workers' compensation coverage

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

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list:

- Each case
- The employee name
- Identifying number
- Date of loss
- Diagnosis

Termination

Automatic termination

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

Termination by you

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

Termination by us

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

- Upon 30 days advance written notice to you:
 - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
 - If you no longer have any employees under the plan who live, reside, or work in the service area
 - If you are a member of an association and your membership in the association ceases
- Upon 30 days written notice to you:
 - If you breach a provision of the group agreement and you do not cure the breach within the notice period
 - If you cease to be a group as defined under applicable state law
 - If you fail to meet our contribution or participation requirements applicable to this group agreement (after the grace period described in the *Premium* section)
 - If you do not certify your compliance with our policies and procedures upon request
 - If you change your eligibility or participation requirements without our consent
- Upon 90 days written notice to you (or such longer notice period as applicable laws require,) if we cease to offer the product provided by this group agreement
- Upon 180 days written notice to you (or such longer notice period as applicable laws require,) if we act as required by applicable federal and state laws for uniform termination of coverage

We may rescind the group agreement and all coverage it provides for fraud or intentional misrepresentation of material fact with 30 days advance written notice. The notice will state the **effective date** of rescission.

You can submit a grievance to us or California Department of Managed Health Care if you believe your coverage has been or will be improperly cancelled, rescinded, or not renewed. Your coverage will continue while your grievance is under review and you pay your premium if you submitted your

grievance before the effective date of the improperly cancelled, rescinded, or not renewed coverage for reasons other than nonpayment.

Effective time of termination

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

Effect of termination

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

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

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

Reinstatement

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

Intentional deception

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

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

We also may report fraud to law enforcement.

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

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

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

Responsibility for conduct

Employees and agents

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

We are not responsible to you for what is done by others, such as **providers**. They are not our employees or agents. **Providers** in our **network** are what the federal and state laws call our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents. We will notify you when a **provider** in our **network** ends or breaches their contract or has an inability to perform. You will tell your employees within 30 days of the notification

Indemnification – in general

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

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

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

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

Indemnification – federal law requirements

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

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

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

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

General provisions

General provisions – content and interpretation of the group agreement

Applicable law

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

Compliance with law

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

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

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

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

Changes to the group agreement

The group agreement may be amended by mutual consent and in writing.

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

We have to give you 120 days advance written notice, and you have to consent in writing to changes in the group agreement. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage
- Will not increase benefits or coverage with a concurrent increase in premium during the current group agreement term, other than increased benefits or coverage required by federal and state laws

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

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

Entire group agreement

The group agreement replaces and supersedes:

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

Waiver

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

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

General provisions – administration of the group agreement

Aetna name, symbols, trademarks and service marks

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

Assignment and delegation

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

We may assign or delegate functions under the group agreement to third parties. For example, management or administration of prescription drug benefits will be performed by CaremarkPCS Health L.L.C. and/or its affiliates (CVS Caremark®), each of which is an affiliated, licensed pharmacy benefit manager. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations – ERISA claim fiduciary

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

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

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

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

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the group agreement, any EOC, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

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

Discrimination prohibited

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

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

Financial Sanctions Exclusions

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

Incontestability

We will not use a statement you make to void this group agreement after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

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

Notice may be delivered:

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

Mail notices to us by mail and commercial carrier:

AETNA HEALTH OF CALIFORNIA INC.

1385 East Shaw Ave.

Fresno, CA 93710

We will send notices to you by mail and commercial carrier:

THE WATERFRONT BEACH RESORT

21100 PACIFIC COAST HWY

HUNTINGTON BEACH, CA 92648

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

Policies and procedures

We have the right to adopt reasonable policies, procedures, rules, and interpretations of the group agreement in order to promote orderly and efficient administration. You and all **covered persons** are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the group agreement.

Third party rights

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

TTY: **711**

[illegible]

Ukrainian	Щоб безкоштовні отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý

Aetna Value Network HMO

Health maintenance organization (HMO)

Evidence of coverage (EOC)

Prepared exclusively for:

Contract holder: THE WATERFRONT BEACH RESORT

Contract holder number: 0175537

Group agreement effective date: September 01, 2025

Plan effective date: September 01, 2025

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



Table of contents

Welcome.....	3
Coverage and exclusions	6
General plan exclusions	29
How your plan works.....	34
Grievance and appeal procedures.....	47
Eligibility, starting and stopping coverage	50
General provisions – other things you should know	56
Glossary	59

Schedule of benefits

Issued with your EOC

Welcome

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

Welcome to Aetna.

Introduction

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

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

This combined EOC and schedule of benefits constitutes only a summary of the health plan. The health plan group agreement must be consulted to determine the exact terms and conditions of coverage.

How we use words

When we use:

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

Contact us

For questions about your plan or request a confidential communication to keep your medical information private, you can contact us by:

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

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

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

Your ID card

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

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

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

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

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to participate in programs, including but not limited to:

- Fitness reimbursement
- Get Active
- Lifestyle and condition coaching
- Neighborhood wellness

Contact us for more information or contact us by using the contact details on the wellness and other reward information you receive once enrolled.

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service **providers**". These third party service **providers** may pay us so that they can offer you their services. Third party service **providers** are independent contractors. The third party service **provider** is responsible for the goods or services they deliver. We 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.

Timely access to care

Network providers agree to provide timely access to care. You will see your **network provider** when you call for an appointment within these timeframes:

- Urgent care within 48 hours of the request
- Non-urgent primary or non-**physician mental health disorder** or **substance use disorder** care within 10 business days of the request and follow-up care for non-physician **mental health disorder** or **substance use disorder** care within 10 business days of the prior appointment
- Non-urgent specialty care or ancillary services within 15 business days of the request

- Telephone screening within 30 minutes of the request

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

You can contact us when you have a complaint or you cannot access care in a timely manner. Contact us by calling the number on your ID card or write to us at:

Customer Service

Aetna Health of California, Inc.

PO Box 24030, Fresno, CA 93779

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

California Department of Managed Health Care

980 9th Street, Suite 500, Sacramento, CA 95814-2725

1-888-466-2219, Fax: 916-255-5241, TDD: 1-877-688-9891

Coverage and exclusions

Providing covered services

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

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

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

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

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

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

Abortion

Covered services include services provided and supplies used in connection with an abortion.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency

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

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

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services that is not medically necessary

Behavioral health

Mental health treatment

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

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **mental health disorders**
 - 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
 - Electro-convulsive therapy (ECT)
 - Transcranial magnetic stimulation (TMS)
 - Psychological testing
 - Neuropsychological testing
 - Observation

- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

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

Substance use disorders treatment

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

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **substance use disorders**
 - Other outpatient **substance use disorders** treatment such as:
 - Partial hospitalization treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
 - Observation
 - Peer counseling support by a peer support specialist including **telemedicine** consultation)

Medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, and evaluation and treatment provided by a CARE agreement or plan approved by a court are covered regardless of whether the service is provided by an in-network or out-of-network provider.

When contacted by a mobile crisis team, Aetna will authorize post-stabilization care or authorize transfer to another provider no more than 30 minutes after receiving the request from a mobile crisis team.

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

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Aetna Health of California Inc. fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization). If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Clinical trials

An approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, treatment of cancer, a life threatening condition or any condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted or delayed. You are eligible to participate in a clinical trial if:

- You are eligible to participate in the approved clinical trial according to the clinical trial rules and procedures
- Your **provider** concluded that your participation is appropriate or you provided medical and scientific information to support your participation

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709. **Covered services** include all routine patient costs provided when you are not participating in an approved clinical trial.

The following are not **covered services**:

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

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** only when you have a seriously debilitating condition, a life-threatening illness or injury, or a **terminal illness**.

You can submit a grievance if we deny, limit, delay or modify your **covered service** for a clinical trial. Please refer to the *Independent medical review* section for more information.

Dental care anesthesia

Covered services include anesthesia and facility costs for dental care. Your doctor must certify that the dental care cannot be performed in the dentist's office due to either age or medical condition.

The following are not **covered services**:

- The related dental service unless specifically listed as a **covered service** in this certificate.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

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

Durable medical equipment (DME)

DME and the accessories needed to operate it are:

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

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

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

Covered services also include:

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

The following are not **covered services**:

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

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911, 988 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or inpatient and outpatient services to evaluate and stabilize a behavioral health crisis by a 988 center or mobile crisis team. You can get **emergency services** from **network providers** or **out-of-network providers**. Behavioral health crisis services means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

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

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

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity, referral and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician (PCP)**.

Non-emergency services

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

Foot orthotic devices

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

Gender affirming treatment

Covered services include services and supplies for gender affirming treatment.

Important note:

Visit <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the toll-free number on your ID card.

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapies

Covered services include:

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

The following are not **covered services**:

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

Home health care

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

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

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

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

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation

Hospice care

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

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

The following are not **covered services**:

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

Hospital care

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

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

The following are not **covered services**:

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

Infertility services

Basic infertility

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

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

Advanced reproductive technology (ART) for fertility preservation

Advanced reproductive technology, also called "assisted reproductive technology", is a more advanced type of **infertility** treatment. **Covered services** include the following services provided by a **network ART specialist**:

- In vitro fertilization (IVF) for fertility preservation.
- Cryopreservation (freezing), and storage for eggs, embryos, sperm or reproductive tissue for fertility preservation.

Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our **infertility** Institutes of Excellence™ (IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **ART** services.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that may directly or indirectly cause **infertility** including but not limited to:
 - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
 - Other gonadotoxic therapies
 - Removing the uterus
 - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy

Aetna's clinical policy for fertility preservation and **infertility covered services** are consistent with established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Infertility services not covered:

- All **infertility** services associated with or in support of an injectable drug (menotropin) cycle, including, but not limited to, imaging, laboratory services, professional services.
- **Infertility** services associated with or in support of an Assisted Reproductive Technology (ART) cycle. These include, but are not limited to:
 - Imaging, laboratory services, professional services
 - In vitro fertilization (IVF), except for fertility preservation
 - Zygote intrafallopian transfer (ZIFT)
 - Gamete intrafallopian transfer (GIFT)
 - Cryopreserved embryo transfers
 - Gestational carrier cycles
 - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- Thawing of eggs, embryos, sperm or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without **surgical** reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Jaw joint disorder treatment

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

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

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

The following are not **covered services**:

- Dental services and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

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

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

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

The following are not **covered services**:

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

Nutritional support

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

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

The following are not **covered services (except for treatment for eating disorders)**:

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

Obesity surgery and services

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

Covered services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the **prescription** drug rider when **prescription** drugs are covered under the plan
- One obesity **surgical** procedure

- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the Prescription drug plan rider
- Stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Outpatient surgery

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

Important note:

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

The following are not **covered services**:

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

Physician services

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

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

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care
- Second opinions (you or your **provider** can request a second opinion)

Important note:

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

All office visits are covered if you use **telemedicine** instead.

Telemedicine will have the same cost sharing. See the schedule of benefits for more information.

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive, except COVID-19 screening and diagnostic testing. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

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

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

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

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

Important note:

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

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

Family planning services – contraceptives

Covered services include family planning services as follows:

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

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

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods or devices, except for male condoms prescribed by a **health professional**

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician, PCP, OB, GYN** or OB/GYN office and includes participation in the California Prenatal Screening Program. The exams include initial and subsequent visits for:

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

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, a pathology exam on any removed polyp, and a follow-up colonoscopy after a positive result on any of the recommended tests or procedures for colorectal cancer screening
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

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

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

- High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

Coverage includes:

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects or repairs abnormal structures of the body caused by:
 - cleft palate (includes medically necessary dental or orthodontic services)
 - congenital defects
 - developmental abnormalities
 - disease
 - infection
 - trauma
 - tumors
- The purpose of the **surgery** is to improve function or create normal appearance

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

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
 - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
 - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy

(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

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

The following are not **covered services**:

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

Skilled nursing facility

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

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

Specialty prescription drugs

Covered 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 freestanding outpatient facility
 - The outpatient department of a **hospital**
 - A **physician** in the office
 - A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription drug** benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician, specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

Covered services for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at <https://www.aetna.com/> to review our **telemedicine provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

Tests, images and labs – outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Biomarker testing
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered 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**.

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include FDA approved GCIT provided by a **physician, hospital** or other **provider**. Refer to the *Clinical trials* section for GCIT not approved by the FDA.

Key Terms

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

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these “GCIT services.”

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza (Nusinersen).
 - siRNA.
 - mRNA.
 - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies

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

Important note:

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

Infusion therapy

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

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

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

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

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

Radiation therapy

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

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

Transplant services

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

This includes the following transplant types:

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

Network of transplant facilities

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

You must get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the IOE facility **copayment, coinsurance, deductible, maximum out-of-pocket** and limits shown in your schedule of benefits.

Important note:

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

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

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an **urgent condition** at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat **urgent conditions**.

Urgent conditions need prompt medical attention but are not life-threatening.

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

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

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

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Adult vision care

Covered services include:

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

The following are not **covered services**:

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

Pediatric vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

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

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

General plan exclusions

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

Behavioral health treatment

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

- Education service
- Services provided in conjunction with school, vocation, work or recreational activities

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

Examples of these are:

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

Cosmetic services and plastic surgery

Any treatment, **surgery** (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body except as **medically necessary** for gender dysphoria

Court-ordered services and supplies

Court-ordered testing or care unless **medically necessary**. This does not include medically necessary services required or recommended by the Community Assistance, Recovery, and Empowerment (CARE) court or plan. CARE Court evaluation and treatment services will be covered regardless of whether the service is provided by an in-network or out-of-network provider.

Custodial care

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

Examples of these are:

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

- For behavioral health (mental health treatment and **substance use disorder** treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
 - Services given mainly to:
 - Maintain, not improve, a level of function
 - Provide a place free from conditions that could make your physical or mental state worse

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as such as routine cutting of nails, when there is no illness or injury in the nails
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes

Gene-based, cellular and other innovative therapies (GCIT)

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
 - Infusion
 - Lab
 - Radiology
 - Anesthesia

- Nursing services

See the *How your plan works – Medical necessity, referral, and precertification requirements* section.

Growth/height care

- A treatment, device, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices to stimulate growth
- Drugs or growth hormones unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

Hearing aids

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing exams

Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss

Medical supplies – outpatient disposable

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Other primary payer

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

Personal care, comfort or convenience items

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

Private duty nursing

Services not permitted by law

Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

Any treatment or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, except for **medically necessary** services to treat a **mental health disorder** or **substance use disorder**:

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

Strength and performance

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

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Treatment in a federal, state, or governmental entity

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

Voluntary sterilization

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

Work related illness or injuries

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

Important note:

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

How your plan works

How your plan works while you are covered

Your HMO plan:

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

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

Providers

Our **provider** network is there to give you the care you need. The easiest way to find **network providers** and see important information about them is by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for more information.

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

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

Service area

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

Who provides the care

Network providers

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

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

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

- Medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team.
- The evaluation and treatment provided by a CARE agreement or plan approved by a court.

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

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

Your PCP

You must get **covered services** through your **PCP**.

How you choose your PCP

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

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

What your PCP will do for you

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

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

Changing your PCP

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

If you do not select a PCP

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

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

How is my PCP paid?

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

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

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

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

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

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

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

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

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

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

If you have this condition	The length of transitional period is
Acute condition (appears suddenly requiring immediate care and does not last long)	As long as the condition lasts
Serious chronic condition (continues or worsens over time and requires ongoing treatment)	No more than 12 months.
Pregnancy	All three trimesters of pregnancy and the immediate post-partum period
Maternal mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery	Up to 12 months after diagnosis or after pregnancy ends, whichever occurs later
Terminal illness	As long as the person lives
Care of child under 3 years	Up to 12 months
An already scheduled surgery or other procedure	Within 180 days of you joining the Aetna plan or your provider leaving the network

If this situation applies to you, contact us for details. As long as the **provider** did not leave the network based on fraud or lack of quality standards, you'll be able to receive transitional care from your **provider** for a period based on your condition. You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Medical necessity, referral and precertification requirements

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

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

- You or your **provider** **precertifies** the service when required

Medically necessary, medical necessity

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

Important note:

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

Referrals

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

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**. You may need **precertification** during the delivery of your care. We will review your request concurrently.

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

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as soon as possible. You can submit a grievance if we deny the **emergency service** as not **medically necessary**. Please see the *Grievance and appeal procedures* section.

Your **physician, PCP**, or the facility must call us within these timelines:

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

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

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your precertified length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be precertified. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

Type of request	Timeframes we decide	Timeframes we provide notification
Urgent care	Within 72 hours as appropriate for the medical condition	Within 24 hours of the decision to your provider Within two business days of the decision in writing to you
Non-urgent care	Within five business days as appropriate for the medical condition	Within 24 hours of the decision to your provider Within two business days of the decision in writing to you
Requests for review after you receive care	Within 30 days	Within 30 days

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

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavioral analysis
Obesity (bariatric) surgery	ART services
Stays in a hospice facility	Complex imaging
Stays in a hospital	Comprehensive infertility services
Stays in a rehabilitation facility	Cosmetic and reconstructive surgery
Stays in a residential treatment facility for treatment of mental health disorders and substance use disorders treatment	Gene-based, cellular and other innovative therapies (GCIT)
	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	In vitro fertilization (IVF) for fertility preservation
	Kidney dialysis

	Knee surgery
	Outpatient back surgery not performed in a physician's office
	Partial hospitalization treatment – mental health disorder and substance use disorders treatment
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist surgery

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

Precertification is not required for services provided by a 988 center or mobile crisis team or treatment provided by a CARE agreement or plan approved by a court (except prescription drugs).

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

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

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:

For certain drugs covered under your medical plan or **prescription** drug plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**. We will tell your **provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact us or go online to get the most up to date **precertification** requirements and list of **step therapy** drugs.

Requesting a medical exception

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

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

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

We will make a coverage decision within 24 hours after we receive your request. We will tell you, someone who represents you and your **provider** of our decision.

If you had approval for a prescription drug under a prior plan, your prescriber can continue to prescribe the same prescription drug for your medical condition under this plan.

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid).

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

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

Some of these arrangements are called:

- Value-based contracting
- Risk sharing

- Accountable care arrangements

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

*For **prescription** drug services:*

When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third-party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Surprise bill

There may be times when you unknowingly receive services or don't consent to receive services from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
 - The out-of-network notice for your signature for your consent to be treated and balance billed
 - The estimated charges for the items and services
 - Notice that the **provider** is an **out-of-network provider**
- Out-of-network air ambulance services

The **out-of-network provider** must get your consent to be treated and balance billed by them.

Ancillary services mean any professional services including:

- Items and services related to emergency medicine
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this instance means an institution providing health care related services or a health care setting. This includes:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**

- Diagnostic, laboratory and imaging centers
- Rehabilitation facilities
- Other therapeutic settings

A surprise bill claim is paid based on the greater of the average contracted rate or 125 percent of the Medicare reimbursement rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent notice for these services. In this case, you are responsible for all charges.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Paying for covered services – the general requirements

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

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

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

You pay the entire expense when:

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

In all these cases, the **provider** may require you to pay the entire charge or you may receive a bill. You or your **provider** may file a post-services claim. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

If we fail to pay the **network provider**, you will not have to pay the **network provider** for any sums that we owe.

Where your schedule of benefits fits in

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

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

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

Post-service claims

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

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

Filing a claim

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

Claim decisions and notifications

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

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

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

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us. Please see the *Grievance and appeal procedures* section for that information.

Coordination of benefits

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

Key Terms

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

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

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

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

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
 - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

Determining who pays

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

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

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

How COB works with Medicare

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

When you are enrolled in Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare.

Other health coverage updates – contact information

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

Our rights

We have the right to:

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

Grievance and appeal procedures

Grievance

You may not be happy about a **provider**, your quality of care, or an operational issue, and you may want to complain. You can contact us at any time. Grievances are:

- Appeals
- Complaints
- Disputes
- Inquiries (considered grievances when a distinction is not determined between them)
- Requests for reconsideration

Your grievance should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision. You can submit your grievance by:

- Calling the toll-free number on your ID card
- Logging on to the Aetna website at <https://www.aetna.com/>
- Writing us at PO Box 24030, Fresno, CA 93779

Some reasons you may file a grievance include:

- Your **PCP** refused to provide a **referral** to a **specialist** or facility
- We were not courteous or prompt when providing services to you
- You are dissatisfied with having to wait so long for an appointment
- We ended your coverage and you think that decision is unfair

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan by calling the toll-free number on your ID card and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhca.ca.gov has complaint forms, IMR application forms and instructions online.

Grievance and appeal procedures

You or your **provider** may contact us at various times to make a grievance. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. You can request an IMR from the DMHC. See the *Independent medical review* section below.

Urgent grievance

You may appeal or your **provider** may appeal for you without having to fill out an appeal form.

Post-service claim appeal

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 by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive an acknowledgment letter within five calendar days. You will receive a decision within 30 calendar days for a post-service grievance. You will receive a decision within five business days for a post-service grievance for a service or supply that is **experimental or investigational**.

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

Independent medical review

An IMR is a review done by an Independent Medical Review Organization (IMRO) managed by the DMHC.

You have a right to an IMR when within six months of the grievance decision if:

- You have received an adverse benefit determination
- We decided the service or supply is not **medically necessary** but your **provider** recommends or determines your service is **medically necessary**
- We decided the service or supply is **experimental or investigational** and your **provider** certifies you have a life-threatening or seriously debilitating illness and has recommended treatment for it
- You have been seen by a network **provider** for the diagnosis or treatment of a medical condition
- A grievance has remained unsolved for more than 30 days or three days for an **urgent condition** or an **emergency medical condition** or a grievance was filed and the decision was upheld

If our grievance decision is one for which you can seek an IMR, 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 IMR process and will include a copy of the IMR application. You will not be charged for an IMR.

You should send the completed application to the DMHC. They will review your grievance and determine if it is eligible for an IMR. We will submit the required documents to the DMHC within three days, or 24 hours for urgent requests, after we receive notice the IMR is approved. The DMHC sends your grievance to the IMRO. The IMRO will determine whether or not the care is **medically necessary**. You will receive a copy of the IMR decision.

How long will it take to get an IMR decision?

The IMR will make their decision in 30 days, or three days for an urgent request

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

For initial adverse benefit determinations

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

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

Recordkeeping

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

Fees and expenses

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The contract holder decides and tells us who is eligible for health coverage. The contract holder is responsible for paying premiums and will tell you the amount and how to pay it.

When you can join the plan

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

You can enroll:

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

You can enroll eligible family members (these are your “dependents”) at this time too.

If you don’t enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

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

Adding new dependents

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

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

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

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

Special times you can join the plan

You can enroll in these situations:

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

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

You can also enroll in these situations:

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

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

Notification of change in status

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

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

Starting coverage

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

Stopping coverage

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

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends at least 30 days prior to that date.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The contract holder asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

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

What happens to your dependents if you die?

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

Why would we end your coverage?

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage within 24 months of your effective date.

These serious consequences include:

- Rescission of coverage (you lose coverage both going forward and going backward)
- Ending your coverage
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind or end your coverage:

- We will give you 30 days advance written notice of any rescission of coverage or ending your coverage
- You have the right to an Aetna appeal
- You have the right to a third-party review conducted by the Department of Managed Health Care

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

We will not end your coverage because of your health status or health care needs. We also will not end your coverage because you filed an appeal. You can submit a grievance to us or California Department of Managed Health Care within 180 days from the date of the notice you receive if you believe your coverage has been or will be improperly cancelled, rescinded, or not renewed. Your coverage will continue while your grievance is under review and you pay your premium if you submitted your grievance before the effective date of the improperly cancelled, rescinded, or not renewed coverage for reasons other than nonpayment.

You also have a grace period of 30 consecutive days beginning the date of the notice you receive is dated. We will give you an answer within 72 hours.

Special coverage options after your coverage ends

When coverage may continue under the plan

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage. The qualifying events are:

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

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

Continuation of coverage for other reasons

To request an extension of coverage, just contact us.

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

Your coverage may be extended if you are totally disabled when coverage ends.

Only the medical condition which caused the total disability is covered during your extension.

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

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

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

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

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

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

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

We will send you a notice at least 90 days before your child reaches the plan age limit. We may ask you to send us proof of the disability within 60 days of the date coverage would have ended or receipt of the notice. 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 after two years. You must send it to us within 60 days of our request. If you don't, we can terminate coverage for your dependent child.

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

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

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

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

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

How your dependent can extend coverage after you die

Your dependents can continue coverage after your death if:

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

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

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

- The date your spouse remarries

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this EOC

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

How we administer this plan

We apply policies and procedures to administer this plan.

Who's responsible to you

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

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

Coverage and services

Your coverage can change

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

Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *Grievance and appeal procedures section*.

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes

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

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. When you assign your benefits to your **out-of-network provider**, we will pay them directly.

Financial sanctions exclusions

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

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

Recovery of overpayments

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

When you are injured

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

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

- Agreeing to repay us from money you receive (not exceeding one third if you used an attorney or one half if you did not use an attorney) because of your injury.
- Giving us the right to seek money in your name, from any person who causes you injury and from your own insurance. We can seek money only up to the amount we paid for your care.
- Agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money for your injury or illness. You'll hold any money you receive until we are paid in full. And you'll give us the right to money you get, ahead of everyone else.
- Agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We may reduce the amount we're due if you are partially responsible for your injury.

Your health information

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

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

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

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be provided to you upon request.

Glossary

Behavioral health provider

A **health professional** who is licensed or certified to provide **covered services** for mental health and **substance use disorders** in the state where the person practices.

A **health professional** who is qualified to provide **covered services** for autism.

Brand-name prescription drug

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

Coinsurance

Coinsurance is the percentage of the bill you pay after you meet your **deductible**.

Copay, copayment

This is the dollar amount you pay for **covered services**. In **prescription** drug plans, it is the amount you pay for covered drugs.

Covered service

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

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

Deductible

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

Detoxification

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

Drug guide

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

Emergency medical condition

A severe condition that:

- Are acute symptoms, including active labor
- Leads you reasonably believe that, without immediate care, it could result in:
 - Danger to life or health
 - Serious impairment of a bodily function

- Serious impairment of function to a body part or organ
- Danger to the health of an unborn baby

Emergency services

Treatment given in a **hospital's** emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An “independent freestanding emergency department” means a health care facility that is geographically separate, distinct and licensed separately from a **hospital** and provides **emergency services**.

Experimental or investigational

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

Formulary exclusions list

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

Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

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

Home health care agency

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

Hospital

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

Infertility

The presence of a demonstrated condition recognized by a licensed **physician** and surgeon as a cause of **infertility** or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw

- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity (services or supplies other than for mental health disorder and substance use disorder)

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

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

Generally accepted standards of medical practice means:

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

Medically necessary/Medical necessity (mental health disorder and substance use disorder)

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

- In accordance with generally accepted standards of **mental health disorder** and **substance use disorder** care
- Clinically appropriate, in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit for us or the convenience of the patient, **physician**, or other health care **provider**

All medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge of a **covered person** diagnosed with **mental health disorders** and **substance use disorders** will be made using the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. You can find the information at <https://www.aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html>.

Mental health disorder

A **mental health disorder** is a condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **mental health disorders** in future versions of the DSM or ICD shall not affect the conditions covered in this section as long as a condition is commonly understood to be a **mental health disorder** by **providers** practicing in relevant clinical specialties.

Negotiated charge

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

Network provider

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

Out-of-network provider

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

Physician

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

Precertification, precertify

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

Preferred drug

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

Prescription

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

Primary care physician (PCP)

A **physician** who:

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

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

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

Provider

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

Psychiatric hospital

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

Referral

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

Residential treatment facility

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

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

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs.

Room and board

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

Semi-private room rate

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

Skilled nursing facility

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

- Rehabilitation **hospitals**

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

Skilled nursing facility does not include institutions that provide only:

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

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

Skilled nursing services

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

Specialist

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

Specialty prescription drugs

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Stay

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

Step therapy

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

Substance use disorder

A **substance use disorder** is a condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* (ICD) or that is listed in the most recent version of the DSM. Changes in terminology, organization, or classification of **substance use disorder** in future versions of the DSM or ICD shall not affect the conditions covered in this section as long as a condition is commonly understood to be a **substance use disorder** by **providers** practicing in relevant clinical specialties.

Surgery, surgical procedure

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

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

Telemedicine

The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Terminal illness

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

Urgent condition

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

Value prescription drugs

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

Walk-in clinic

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

- Drug store

- Pharmacy
- Retail store
- Supermarket

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

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

Important Information about the Affordable Care Act (ACA)

Non-discrimination Rule

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

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

Important note:

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

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

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

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

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

- Shall not:
 - Deny or limit coverage
 - Deny or limit coverage of a claim
 - Apply additional cost sharing

to a transgender person, if it results in discrimination against that person.

- Shall not exclude or limit health services related to gender transition.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates. Aetna companies that receive funds from the federal Department of Health and Human Services are subject to the Rule.

Your Health Insurance Choices Are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Covered California

You can buy health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

If you are eligible for the Medicare Program you should examine your options carefully, as delaying Medicare enrollment may result in substantial financial implications.

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open enrollment begins on October 15 of every year and ends on January 31 of the following year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs (“special enrollment period”).

Through Covered California, you may also get help paying for your health insurance. You can:

- Reduce your out of pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the U.S.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment periods, but the financial help is available only if you select a Covered California product.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California’s health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U. S. citizen, U.S. national or lawfully present in the U.S age 26 and older;
- Your income is low; and
- You are an adult age 19 through 25 who does not have satisfactory immigration status or is unable to establish satisfactory immigration status or to verify United States citizenship.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

You can also get Medi-Cal if you are:

- Age 21 or younger
- Age 65 or older
- Blind
- Disabled
- Pregnant
- In a skilled nursing or intermediate care home
- On refugee status for a limited time, depending how long you have been in the United States
- A parent or caretaker relative of an age eligible child
- Have been screened for breast and/or cervical cancer

Other rules or requirements may apply.

For More Information

To learn more about Covered California or Medi-Cal, visit <https://www.coveredca.com/> or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

Aetna Health of California Inc. Rider

Prescription drug plan

Rider effective date: September 01, 2025

This **prescription** drug plan rider is added to your evidence of coverage (EOC). It describes your **prescription** drug benefits. This rider is subject to all other requirements described in your EOC, including general exclusions and defined terms.

How to access your benefit

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

Important note:

A pharmacist may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section for more information.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a generic drug when it is available.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications and would like to have them each dispensed on the same fill date for your convenience, your network pharmacy may be able to coordinate that for you. This is called synchronization. We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

How to access network pharmacies

A network pharmacy will submit your claim. You will pay your cost share to the pharmacy. You can find a network pharmacy online or by phone. See the *Contact us* section in your certificate for how. You may go to any of our network pharmacies. If you don't get your **prescription** at a network pharmacy, it will not be a **covered service** under the plan, except for medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services, provided by a 988 center or mobile crisis team or treatment provided by a CARE agreement or plan approved by a court are covered by an out-of-network pharmacy. You can access a list of preferred network pharmacies by contacting us.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

After you obtain your second fill at a network **retail pharmacy**, you must tell us whether you want to use your network **mail order pharmacy** benefit, or a CVS pharmacy, or continue to use your network **retail pharmacy**. See the *Contact us* section for how. If you don't tell us your choice, the next **prescription** refill and any other refills at a network **retail pharmacy** will not be covered. You can tell us at any time that you intend to use a network **retail pharmacy** for future **prescription** refills

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

All **specialty prescription drug** fills including the first fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

Partial fills

A partial fill of a Schedule II controlled substance may be dispensed when you or your prescriber request it. Your cost share will be prorated accordingly.

When the pharmacy you use leaves the network

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

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share will be
A network pharmacy	The plan cost share
An out-of-network pharmacy	The full cost of the prescription

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

- You will fill out and send a **prescription** drug refund form to us, including all itemized pharmacy receipts
- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the **prescription** less your network cost share

Other covered services

Abortion drugs

Covered services include **prescription** drugs used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

For females who are able to become pregnant, your **prescription** drug plan covers certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Covered services include items such as:

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

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

Immunizations

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

Infertility drugs

Covered services include oral **prescription** drugs used to treat the underlying medical cause of infertility.

Obesity drugs

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

You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with morbid obesity.

Off-label use

Covered services may include off-label use of FDA-approved prescription drugs when it is not approved for your condition. Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition as stated in:
 - 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 condition and the dosage has been proven as safe and effective by at least one well-designed controlled clinical trial, and published in a peer reviewed medical journal known throughout the U.S.
- Your dosage of a drug is equal to the dosage for the same condition as suggested in the FDA-approved labeling or by one of the standard references stated above

Services related to off-label use of these drugs may:

- Require precertification
- Require **step therapy**
- Have additional requirements
- Have limits

Over-the-counter (OTC) drugs

Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to your member website.

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC drugs and supplements, as required by the ACA.

Risk reducing breast cancer prescription drugs

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

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

Sexual dysfunction or enhancement drugs

Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement for medically necessary services to treat a mental health disorder or substance use disorder. **Covered services** include **prescription** drugs for the treatment of sexual dysfunction or enhancement for other reasons. See the *Contact us* section for how to find the most up-to-date information on dosing.

Tobacco cessation prescription and OTC drugs

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

Exclusions

The following are not **covered services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes, except as **medically necessary** for gender dysphoria
- Dietary supplements
- Drugs or medications
 - Administered or entirely consumed at the time and place they are prescribed or provided
 - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
 - Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ except for medically necessary services to treat a mental health disorder or substance use disorder
 - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications, unless you are diagnosed by your **provider** with an eating disorder or morbid obesity
 - That are drugs or growth hormone used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

- Duplicative drug therapy, for example, two antihistamines for the same condition
- Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule or the certificate
- **Infertility:**
 - Injectable **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
 - Any charges for the administration or injection of **prescription** drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Where your schedule of benefits fits in

This schedule of benefits (schedule) lists the **deductibles**, **copayments** or **coinsurance**, if any apply to the **covered services** you receive under the **prescription** drug plan. You should review this schedule to become aware of these and any limits that apply to these services.

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

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

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

Precertification requirements that apply

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. This is called **precertification**. The requirement for getting approval in advance guides appropriate use of

certain drugs and makes sure they are **medically necessary**. We will tell your **provider** the decision within 72 hours or within 24 hours when you have an **emergency medical condition**.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact us or go online to get the most up-to-date **precertification** requirements and list of step therapy drugs.

Utilization review

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

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

Requesting a medical exception

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

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

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

We will make a coverage decision within 24 hours after we receive your request. We will tell you, someone who represents you and your **provider** of our decision. You can refer to the *Grievance and appeal procedure* section for more information on denial of coverage.

If you had approval for a prescription drug under a prior plan, your prescriber can continue to prescribe the same prescription drug for your medical condition under this plan.

Your cost share will not be more than the retail drug price. The amount you pay for the **prescription** drug will apply to your **maximum out-of-pocket limit and deductible if you have one**.

How to read your schedule of benefits

How your cost share works

- The **deductibles, copayments and coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles, copayments and coinsurance**, if they apply and before the plan will pay for any **covered services**.
- Your **copayment or coinsurance** is the amount you pay for each **prescription** fill or refill. The schedule of benefits shows you the cost share you need to pay for a specific **prescription** fill or refill.
- This plan doesn't cover every **prescription** drug. You pay the full amount of any **prescription** drug you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **provider** or contact us if you have a question about what your cost share will be.

Important note:

All **covered services** are subject to the calendar year **deductible, maximum out-of-pocket**, limits, **copayment or coinsurance** described in the medical plan schedule of benefits unless otherwise stated in this schedule.

Plan features

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to female contraceptive methods when obtained at a network pharmacy. This means they will be paid at 100%. This includes certain OTC and generic contraceptive **prescription** drugs and devices for each of the methods identified by the FDA. If a **generic prescription drug** is not available, the **brand-name prescription drug** for that method will be paid at 100%.

The **prescription** drug **deductible** and cost share will apply to **prescription** drugs that have a generic equivalent or alternative available within the same therapeutic drug class obtained at a network pharmacy unless we approve a medical exception. A therapeutic drug class is a group of drugs or medications that have a similar or identical mode of action or are used for the treatment of the same or similar disease or injury.

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%.

General coverage provisions

Prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services**

Covered services

Generic prescription drugs

Description	In-network
30 day supply at a retail pharmacy	\$10
90 day supply at retail pharmacy	3 times the 30 day amount
90 day supply at mail order pharmacy , or a CVS pharmacy	\$20

Preferred brand-name prescription drugs

Description	In-network
30 day supply at retail pharmacy	\$30
90 day supply at retail pharmacy	3 times the 30 day amount
90 day supply at mail order pharmacy , or a CVS pharmacy	\$60

Non-preferred brand-name prescription drugs

Description	In-network
30 day supply at retail pharmacy	\$50
90 day supply at retail pharmacy	3 times the 30 day amount
90 day supply at mail order pharmacy , or a CVS pharmacy	\$100

Specialty prescription drugs

Description	In-network
30 day supply at a specialty pharmacy or a retail pharmacy	30% but no more than \$250

Anti-cancer drugs taken by mouth

Description	In-network
30 day supply	\$0
90 day supply at mail order pharmacy	\$0

Contraceptives (birth control)

Brand name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network
30 day supply or 12 month supply of generic and OTC drugs and devices	\$0
30 day supply or 12 month supply of brand name prescription drugs and devices	Paid based on the tier of drug in the schedule

Diabetic supplies, drugs

Description	In-network
30 day supply at a retail pharmacy	Paid based on the tier of drug in the schedule
90 day supply at a retail pharmacy	Paid based on the tier of drug in the schedule
90 day supply at mail order pharmacy , or a CVS pharmacy	Paid based on the tier of drug in the schedule

Preferred generic and brand name insulin

Description	In-network
30 day supply at a retail pharmacy	\$25, no deductible applies
90 day supply at a retail pharmacy	3 times the 30 day amount
90 day supply at mail order pharmacy , or a CVS pharmacy	\$75, no deductible applies

Preventive care drugs and supplements

Description	In-network
Preventive care drugs and supplements	\$0
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF). For a current list of covered drugs and supplements or more information see the <i>Contact us</i> section.

Risk reducing breast cancer prescription drugs

Description	In-network
Risk reducing breast cancer prescription drugs	\$0
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF. For a current list of covered risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section.

Tobacco cessation prescription and OTC drugs

Description	In-network
Tobacco cessation prescription and OTC drugs	\$0
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the <i>Contact us</i> section.

Prescription drug important note:

If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug.

Schedule of benefits

Prepared for:

Contract holder: THE WATERFRONT BEACH RESORT

Contract holder number: 0175537

HMO group agreement effective date: September 01, 2025

Plan name: AETNA CONNECTED PLAN WITH CVS HEALTH, HMO

Plan effective date: September 01, 2025



Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** or **coinsurance**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles, copayments** and **coinsurance**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
- You are responsible to pay any **deductibles, copayments** and **coinsurance** if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits.
See the schedule of benefits for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>.

Important note:

Covered services are subject to the calendar year **deductible, maximum out-of-pocket**, limits, **copayment** or **coinsurance** unless otherwise noted in this schedule of benefits. The *Surprise bill* section in the certificate explains your protections from a surprise bill

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share for **covered services** from your selected **PCP**. If you do not select a PCP, we will choose one for you.

How your maximum out-of-pocket works

This schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your evidence of coverage (EOC).

Aetna Health of California Inc.'s HMO group agreement provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your EOC.

Plan features

Maximum out-of-pocket limit

Maximum out-of-pocket type	In-network
Individual	\$2,000 per calendar year
Family	\$4,000 per calendar year

General coverage provisions

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

Deductible credit

If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Copayment

This is a flat fee you pay for certain visits or **covered services**. A copay can be a dollar amount or percentage. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Coinsurance

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

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

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-**covered services** which are identified in the EOC and the SOB

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the group agreement.

Covered services

Cost share based on type of service and where or **provider** from which it is received means your cost share is determined by the **provider** who provides your **covered service**.

Your **telemedicine** cost share will not be more than your in-person visit for the same **covered service**.

Abortion

Description	In-network
Abortion	\$0 per visit no deductible applies

Acupuncture

Description	In-network
Acupuncture	\$15 per visit

	no deductible applies
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Visit limit per year	20
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Ambulance services

Description	In-network
Emergency services	\$150 per trip

	no deductible applies
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Non-emergency services	Not covered
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Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services-room and board including residential treatment facility	\$500 per admission

	no deductible applies
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Other inpatient services and supplies Other residential treatment facility services and supplies	No charge
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Outpatient office visit to a physician or behavioral health provider	\$30 per visit no deductible applies
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Physician or behavioral health provider telemedicine consultation	\$30 per visit no deductible applies
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Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider	\$0 per visit no deductible applies
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Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	\$0 per visit
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	no deductible applies
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Telemedicine provider mental health disorders consultation	Cost share based on type of service and provider from which it is received
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*988 center or mobile crisis team services are covered with applicable cost share in-network and out of network. Evaluation and treatment provided by a CARE agreement or plan approved by a court are covered with no cost share regardless of whether the service is provided by an in-network or out-of-network provider.

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network
Inpatient services – room and board during a hospital stay	\$500 per admission

	no deductible applies
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Other inpatient services and supplies during a hospital stay	No charge
---	-----------

Outpatient office visit to a physician or behavioral health provider	\$30 per visit no deductible applies
---	--

Physician or behavioral health provider telemedicine consultation	\$30 per visit no deductible applies
--	--

Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider	\$0 per visit no deductible applies
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Other outpatient services including: - Behavioral health services in the home - Partial hospitalization treatment - Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	\$0 per visit
---	---------------

	no deductible applies
--	------------------------------

Telemedicine provider substance related disorders consultation	Cost share based on type of service and provider from which it is received
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Clinical trials

Description	In-network
Experimental or investigational therapies	Cost share based on type of service and where it is received
Routine patient costs	Cost share based on type of service and where it is received

Diabetic services, supplies, equipment, and self-care programs

Description	In-network
Diabetic services	Cost share based on type of service and where it is received
Diabetic supplies	Cost share based on type of service and where it is received
Diabetic equipment	Cost share based on type of service and where it is received
Diabetic self-care programs	Cost share based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network
DME	\$20 per item

	no deductible applies
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Emergency services

Description	In-network
Emergency room	\$300 per visit

	no deductible applies
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Emergency services important note:

Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** as an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network
Orthotic devices	\$0 per item

	no deductible applies
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Gender affirming treatment

Description	In-network
Gender affirming treatment	Cost share based on type of service and where it is received

Habilitation therapy services**Outpatient physical (PT), occupational (OT) therapies**

Description	In-network
PT, OT therapies	\$0 per visit no deductible applies

Outpatient speech therapy (ST)

Description	In-network
ST therapy	\$0 per visit no deductible applies

Home health care

A visit is a period of 4 hours or less

Description	In-network
Home health care	\$30 per visit no deductible applies

Visit limit per day	3 intermittent visits
Limit per year	unlimited

Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network
Inpatient services - room and board	\$500 per admission
	no deductible applies
Other inpatient services and supplies	No charge
Outpatient services	\$30 per visit
	no deductible applies

Hospice important note:

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 24 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 24 hours a day.

Hospital care

Description	In-network
Inpatient services – room and board	\$500 per admission
	no deductible applies
Other inpatient services and supplies	No charge

Infertility services**Basic infertility**

Description	In-network
Treatment of basic infertility	Cost share based on type of service and where it is received

Advanced reproductive technology (ART) for fertility preservation

Description	In-network
In vitro fertilization (IVF) for fertility preservation	Cost share based on type of service and where it is received

Jaw joint disorder

Includes TMJ

Description	In-network
Jaw joint disorder treatment	\$30 per visit

	no deductible applies
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Maternity and related newborn care

Includes complications

Description	In-network
Inpatient services – room and board	\$500 per admission

	no deductible applies
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Other inpatient services and supplies	No charge
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Services performed in physician or specialist office or a facility	\$20 per visit
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	no deductible applies
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Other services and supplies	Cost share based on type of service and where it is received
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Maternity and related newborn care important note:

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the EOC. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network
Nutritional support	\$20 per item

	no deductible applies
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Obesity (bariatric) surgery

Description	In-network
Inpatient services – room and board	Cost share based on type of service and where it is received

Outpatient surgery

Description	In-network
At hospital outpatient department	\$300 per visit

	no deductible applies
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At facility that is not a hospital	\$100 per visit
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	no deductible applies
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At the physician office	Cost share based on type of service and where it is received
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Physician and specialist services

Including surgical services

Your PCP

Description	In-network
Physician office hours (not surgical, not preventive)	\$20 per visit no deductible applies

Immunizations that are not considered preventive care	Cost share based on type of service and where it is received.
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Physician visit during inpatient stay	\$20 per visit no deductible applies
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Physician home visit (not preventive)	\$20 per visit no deductible applies
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Physician surgical services	\$20 per visit no deductible applies
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Physician telemedicine consultation	\$20 per visit no deductible applies
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Telemedicine provider consultation	Cost share based on type of service and provider from which it is received
Basic medical services	

Specialist

Description	In-network
Specialist office hours (not surgical, not preventive)	\$30 per visit no deductible applies

Specialist home visit (not preventive)	\$30 per visit no deductible applies
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Specialist surgical services	\$30 per visit no deductible applies
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Specialist telemedicine consultation	\$30 per visit no deductible applies
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Telemedicine provider consultation	Cost share based on type of service and provider from which it is received
Specialist services	

Preventive care

Description	In-network
Preventive care services	\$0 no deductible applies
Breast feeding support and counseling and limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 1 year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for obesity, healthy diet visit limit per day	1
Counseling for obesity, healthy diet visit limit	26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection visit limit	2 visits/12 months
Counseling for tobacco cessation visit limit per day	1
Counseling for tobacco cessation visit limit	8 visits/12 months

Description	In-network
Immunizations limit	Covered persons age 0-99 Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section of your EOC
Routine lung cancer screening limit	1 screening every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year 3 exams every 12 months age 1-2 3 exams every 12 months age 2-3 and 1 exam every 12 months after that age, up to age 22 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Includes medical wigs

Description	In-network
Prosthetic devices	\$0 per item

	no deductible applies
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Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network
Surgery and supplies	Cost share based on type of service and where it is received

Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

Cardiac rehabilitation

Description	In-network
Cardiac rehabilitation	\$30 per visit no deductible applies

Pulmonary rehabilitation

Description	In-network
Pulmonary rehabilitation	\$30 per visit no deductible applies

Cognitive rehabilitation

Description	In-network
Cognitive rehabilitation	Cost share based on type of service and where it is received

Physical, occupational therapies

Description	In-network
At the physician office	\$30 per visit no deductible applies
At facility that is not a hospital	\$30 per visit no deductible applies
At hospital outpatient department	\$30 per visit no deductible applies

Speech therapy (ST)

Description	In-network
At the physician office	\$30 per visit no deductible applies
At facility that is not a hospital	\$30 per visit no deductible applies
At hospital outpatient department	\$30 per visit no deductible applies

Spinal manipulation

Description	In-network
At the physician office	\$15 per visit no deductible applies
At facility that is not a hospital	\$15 per visit no deductible applies

Description	In-network
At hospital outpatient department	\$15 per visit no deductible applies

Visit limit per day	1
Visit limit per year	20

Skilled nursing facility

Description	In-network
Inpatient services – room and board	\$500 per admission

	no deductible applies
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Day limit per year	100
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Other inpatient services and supplies	No charge
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Tests, images and labs - outpatient

Diagnostic complex imaging services

Description	In-network
At facility that is not a hospital	\$100 per visit no deductible applies
At hospital outpatient department	\$100 per visit no deductible applies

Diagnostic lab work

Description	In-network
At facility that is not a hospital	\$0 per visit no deductible applies
At hospital outpatient department	\$0 per visit no deductible applies

Diagnostic x-ray and other radiological services

Description	In-network
At facility that is not a hospital	\$0 per visit no deductible applies
At hospital outpatient department	\$0 per visit no deductible applies

Therapies

Chemotherapy

Description	In-network
Chemotherapy services	Cost share based on type of service and where it is received

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Non-designated network facility/provider (Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/ providers)
Services and supplies	Cost share based on type of service and where it is received	Not covered
Gene therapy products, prescription drugs	\$50 per visit no deductible applies	Not covered

Infusion therapy

Outpatient services

Description	In-network
In physician office	\$30 per visit

	no deductible applies
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At an infusion location	\$300 per visit
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	no deductible applies
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In the home	\$30 per visit
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	no deductible applies
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At hospital outpatient department	\$300 per visit
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	no deductible applies
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At facility that is not a hospital	\$300 per visit
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	no deductible applies
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Radiation therapy

Description	In-network
Radiation therapy	Cost share based on type of service and where it is received

Transplant services

Description	Network (IOE facility)	Network non-IOE facility (Including providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	\$500 per admission	Not covered
	no deductible applies	

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network
Urgent care facility	\$50 per visit
	no deductible applies
Complex imaging, lab and radiology services	No charge
Non-urgent use of an urgent care facility or provider	Not covered

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Adult vision care

Description	In-network
Adult vision exam	\$0 per visit
	no deductible applies
Limit	Limited to covered persons age 19 and older
Visit limit	1 every 24 months

Pediatric vision care

Description	In-network
Pediatric vision exam	\$0 per visit
	no deductible applies
Limit	Limited to covered persons through the end of the month in which the person turns 19
Visit limit	1 every 24 months

Voluntary sterilization

Description	In-network
Tubal ligation and other similar sterilization procedures	\$0 no deductible applies
Vasectomy	\$0 no deductible applies

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	Designated network	Non-designated network
Non-emergency services	\$0 per visit	\$0 per visit

	no deductible applies	no deductible applies
Telemedicine consultation for non- emergency services through a walk-in clinic	\$0 per visit no deductible applies	Not covered
Preventive care immunizations	\$0 per visit no deductible applies	\$0 per visit no deductible applies
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Preventive screening and counseling services	\$0 per visit no deductible applies	\$0 per visit no deductible applies
Telemedicine consultation for preventive screening and counseling services through a walk-in clinic	\$0 per visit no deductible applies	Not covered
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule
Important note: Key terms Designated network provider A network provider listed in the directory under <i>Maximum savings</i> as a provider for your plan. Non-designated network provider A provider listed in the directory under <i>Standard savings</i> as a provider for your plan. See the <i>Contact us</i> section if you have questions. You will pay less cost share when you use a designated network walk-in clinic provider. Non-designated network walk-in clinic providers are available to you, but the cost share will be at a higher level when these providers are used.		