Aetna
Open Choice
Network

WEA Select
Basic

Plan effective November 1, 2018

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Open Choice®
Preferred Provider Organization (PPO)

Medical Expense Insurance Plan
Booklet-certificate

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Welcome

Thank you for choosing **Aetna**.

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

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

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan for in-network and out-of-network coverage.

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Let's get started!

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

Some notes on how we use words

- When we say "you" and "your", we mean both you and any covered dependents
- When we say "us", "we", and "our", we mean **Aetna**
- Some words appear in **bold** type. We define them in the *Glossary* section

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

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network and out-of-network coverage for medical insurance coverage.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons. To learn more see the *When coverage ends* section.

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

How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- You will pay less cost share when you use a **network provider**.

1. **Eligible health services**

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

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

   - They are listed in the *Eligible health services under your plan* section of this booklet-certificate and in the schedule of benefits

- They are not carved out in the *What your plan doesn't cover – some eligible health service exclusions* section (we refer to this section as the "exclusions" section)
- They are not carved out in the exclusions section specific to that service or condition
- They are not beyond any limits in the schedule of benefits

2. **Providers**
   Aetna's network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your **Aetna** secure member website at www.aetna.com.

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

3. **Service area**
   The Washington **service area** is statewide without limitations.

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

   You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section.

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

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

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

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

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

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

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna network**. It's called out-of-network coverage.

Your out-of-network coverage means:

- You can get care from **providers** who are not part of the **Aetna network.**
- You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider.**
- That when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**. Precertification can be requested by either you or your **out-of-network provider**.
- You will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section
- **Out-of-network providers** and any exclusions in the *Who provides the care* section
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits
- Claim information in the *When you disagree - claim decisions and appeals procedures* section

How to contact us for help

We are here to answer your questions. Your plan of benefits includes the **Aetna** Concierge program. The program provides immediate access to healthcare resource consultants who have been specifically trained in the details of your plan.

Register for our secure Internet access to reliable health information, tools and resources. **Aetna** online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can contact us by:

- Calling your **Aetna** Concierge at the number on your ID card from 8:00 a.m. to 6:00 p.m. Monday through Friday
- Logging onto www.aetna.com

Your member ID card

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

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

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or

if you’ve lost it, you can print a temporary ID card. Just log into your **Aetna** secure member website at www.aetna.com.

Who the plan covers

You will find information in this section about:
- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

You are eligible if you are a WEA member who works at least 17.5 hours a week in any division of the Washington Public Schools or the WEA and its Affiliates. If your participating employee group contributes toward the cost of the plan's coverage, the WEA membership and 17.5 hours per week requirements will be waived.

To remain eligible during a school year, a senior substitute teacher must stay in the substitute pool and remain classified as a substitute or regular teacher as defined by the district. School board members are not eligible for coverage unless they are paid employees of the school district and meet the standard WEA eligibility requirements. School board members who receive compensation for their services as board members are not considered employees for this purpose.

Eligible employees must enroll within 30 days of their effective date or at the annual open enrollment period. Please see your school district administrator for enrollment information.

Coverage begins on the first of the month coinciding with the benefits effective date, provided the subscription charges are remitted on a timely basis.

An employee may only be enrolled as a subscriber in a WEA Select Medical Plan through one school district.

Age 65/Continuing employment as an active employee

If you are either an active employee or an active employee's covered spouse and are age 65 or over, the WEA Select Medical plan will provide primary coverage and Medicare coverage will be secondary.

When you can join the plan

As an employee you can enroll yourself and your dependents:
- At the end of any required waiting period
- Once each **plan year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

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

Who can be on your plan (who can be your dependent)

If your plan includes coverage for dependents, you can enroll the following family members on your

plan. They are referred to in this booklet-certificate as your "dependents".

- Your legal spouse
- Your domestic partner
- Your dependent children (your own or those of your spouse or domestic partner)
  - The children must be under 26 years of age, and they include:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Children you are responsible for under a qualified medical support order or court order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship

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

Adding new dependents

If your plan includes coverage for dependents, you can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage
  - The benefits for your spouse will begin the first day of the month following the date of marriage
- A domestic partner - If you enter a domestic partnership, you can put your domestic partner on your plan
  - We must receive your completed enrollment information not more than 31 days after the date your domestic partnership is filed
  - The benefits for your domestic partner will begin the first day of the month following the date of your domestic partnership
- A newborn child - Your newborn child is covered on your plan for the first 31 days after birth
  - When additional **premiums** are required, you must enroll the child within 60 days of birth to keep the newborn covered
  - If you miss this deadline, your newborn will not have benefits after the first 31 days
- An adopted child - You may put an adopted child on your plan on the date the child is placed for adoption
  - "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child
  - When additional **premiums** are required, you must enroll the child within 60 days of placement
  - Your adopted child's coverage will start from the date of placement
  - If you miss this deadline, your adopted child will not have benefits
- A stepchild - You may put a child of your spouse or domestic partner on your plan
  - You must enroll the child within 60 days of the date of your marriage or domestic partnership with your stepchild's parent
  - The benefits for your stepchild will begin the first day of the month following the date we

receive your completed enrollment information

Inform us of any changes

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

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

Special times you and your dependents can join the plan

You can also enroll in these situations:

- You or your dependents did not enroll in this plan before because you:
  - Were covered by another plan, and now that coverage has ended
  - Were covered by Medicaid or an S-CHIP plan, and now no longer qualify
  - Had COBRA, and now that coverage has ended
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan
  - If you are eligible for medical assistance in Washington, the Department of Social and Health Services will send you a notice to enroll in this plan
  - You must complete your enrollment information and send it to us within 31 days after the notice
  - For dependent children, you must complete the enrollment information and send it to us within 60 days of the notice
- You have added a dependent because of marriage, domestic partnership, birth or adoption (see the *Adding new dependents* section for more information)
- A court orders that you cover a current spouse or domestic partner or a minor child on your plan

We must receive your completed enrollment information within 60 days of that date on which you no longer have the other coverage mentioned above.

Important note: A court may order that you cover a minor child on your plan, even if you are not the custodial parent. If that happens, the **provider** or the custodial parent may file a claim for benefits without your approval. Any benefits to be paid will be paid to either the **provider** or to the custodial parent.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for benefits.

Medical necessity and precertification requirements

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

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

- The **eligible health service** is **medically necessary**
- You or your **provider precertifies** the **eligible health service** when required

This section addresses the **medical necessity** and **precertification** requirements.

Medically necessary; medical necessity

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

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

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.

Precertification

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

In-network

Your **network provider** is responsible for obtaining any necessary **precertification** before you get the care. If your **network provider** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **network provider** fails to ask us for **precertification**. If your **network provider** requests **precertification** and we refuse it, you can still get the care but the plan won’t pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exclusions – when you pay all* section.

Out-of-network

When you go to an **out-of-network provider**, it is your responsibility to make sure that **precertification** is obtained from us for any services and supplies on the **precertification** list. **Precertification** can be requested by either you or your **out-of-network provider**. If **precertification** is not received, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section.

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

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

We will provide a written notification to you and your **health professional** of the **precertification** decision. If your **precertified** services are approved**,** the approval is valid for 6 months as long as you remain enrolled in the plan**.**

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

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

What if you don't obtain the required precertification?

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

- Your benefits may be reduced, or the plan may not pay any benefits
- You will be responsible for the unpaid balance of the bills
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductibles** or **maximum out-of-pocket limits**

Sometimes, unforeseen events prevent your **network provider** from obtaining the required **precertification**. These are called extenuating circumstances. For example, if your **network provider** could not reasonably:

- Determine who to request **precertification** from
- Anticipate the need for **precertification** before providing the services
- Request **precertification** for services needed after a **stay**, such as home health care, before the services are required

Your **network provider** can let us know if any extenuating circumstances kept them from obtaining **precertification**. We will work with your **network provider** to make a decision on whether or not the **precertification** requirement should be waived. But, we will still review the claim to make sure that the services were **covered benefits**.

What types of services require precertification?

Precertification may be required for the following types of services and supplies:

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

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs**:

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the number on your ID card or log on to your **Aetna** secure

member website at www.aetna.com.

There is another type **of precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can obtain the most up-to-date information about **step therapy prescription drugs** by calling the number on your ID card or by logging on to your **Aetna** secure member website at www.aetna.com. Your doctor can find additional details about the **step therapy prescription drugs** in our clinical policy bulletins.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not covered or for **brand-name** or **specialty prescription drugs** or for which health care services are denied through **precertification** and **step therapy**. You or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

If we deny your medical exception, you may have the right to a review by an independent external review organization. We will send you a notice that describes this review process. You or your representative will receive notice of review determinations within 72 hours of receiving your request or within 24 hours in exigent circumstances.

Eligible health services under your plan

The information in this section is the first step to understanding your plan's **eligible health services**.

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

For example:

- **Physician** care generally is covered but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.
- Short-term rehabilitation services, such as physical therapy, are generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the Exclusions section, and about the limitations in the schedule of benefits.

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

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

1. Preventive care and wellness

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

Important notes:

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

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

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

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

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **health professional** or **Aetna** by logging on to your **Aetna** secure

member website at www.aetna.com or calling the number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine physical exams

Eligible health services include office visits to your **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **health professional** 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
    - Depression screening, including screening for maternal depression
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women
- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial **hospital** checkup

Exclusions

Your plan does not cover the following under this section:

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by, or under, a **health professional's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Preventive care immunizations

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

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your **health professional**, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.

- Preventive care breast cancer (BRCA) gene blood testing by a **health professional** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Exclusions

Your plan does not cover the following under this section:

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by, or under, a **health professional's** direction
- Psychiatric, psychological, personality or emotional testing or exams

Preventive screening and counseling services

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

- **Obesity and/or healthy diet counseling**
  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

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

- **Use of tobacco products**
  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**
  Eligible health services include counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**
  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies, including removal of polyps during a screening procedure and a pathology exam on any removed polyps
- Lung cancer screenings

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

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

Eligible health services for colorectal cancer screenings include coverage for examinations and laboratory tests as recommended by your **health professional** if you are less than 50 years of age and at high risk or very high risk for colorectal cancer.

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network OB, GYN or OB/GYN.

Prenatal care

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

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

This also includes complications of pregnancy. You can get this care at your **health professional's** office, including your OB's, GYN's, or OB/GYN's office.

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

Comprehensive lactation support and counseling services

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

Breast feeding durable medical equipment

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

Breast pump

Eligible health services include:

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

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

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

Breast pump supplies and accessories

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

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, 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.

Family planning services – female contraceptives

Eligible health services include family planning services such as:

Counseling services

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

Devices

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

Voluntary sterilization

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

Exclusions

Your plan does not cover the following under this section:

- Services and supplies provided for an abortion
- 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, sterilization procedures or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement

Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Treatment of basic infertility*

2. Physicians and other health professionals

Physician, specialist and other health professional services

Eligible health services include services by your **health professional**, including a naturopath, to treat an **illness** or **injury**. You can get those services:

- At the **health professional's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine** or **store and forward technology**

Important note: Your plan covers **telemedicine** and **store and forward technology** only when you get your services through a **provider** that has contracted with **Aetna**.

We will cover office visits covered with a **behavioral health provider** if you use **telemedicine** or **store and forward technology**.

Other services and supplies that your **health professional** may provide:

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

Physician surgical services

Eligible health services include the services of:

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

Alternatives to physician or other health professional office visits

Walk-in clinic

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

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

3. Hospital and other facility care

Hospital care

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

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

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **health professionals** employed by the **hospital.**
- Operating and recovery rooms.
- Intensive or special care units of a **hospital.**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

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

Exclusions

Your plan does not cover the following under this section:

- The services of any other **physician** who helps the operating **physician**, unless **medically necessary**
- A **stay** in a **hospital** (**hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

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

Home health care

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

- You are homebound
- Your **health professional** 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, palliative care 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 (**R.N.**)
- Medical social services are provided by or supervised by a **physician**, other **health professional** or social worker

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 the *Short-term rehabilitation services* and *habilitation therapy services* sections and the schedule of benefits.

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

Exclusions
Your plan does not cover the following under this section:
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

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

The types of **hospice care** services that are eligible for coverage include:
- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a **hospice care agency** or **hospice care** provided in a **hospital**
- Bereavement counseling
- Respite care
- Palliative care

Hospice care services provided by the **providers** below may be covered, even if the **providers** are not an employee of the **hospice care agency** responsible for your care:
- A **physician** or other **health professional** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling
  - Palliative care

Exclusions

Your plan does not cover the following under this section:

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

Outpatient private duty nursing

Eligible health services include private duty nursing care provided by an **R**.**N**. or **L**.**P**.**N**. for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate.

Eligible health services also include private duty nursing care provided by an **R**.**N**. or **L**.**P**.**N**. for management and care of ventilator and stable tracheostomy (including intermittent suctioning) for up to 16 hours a day.

Skilled nursing facility

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

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

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

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

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

4. Emergency services and urgent care

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

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**. **Emergency services** from **out-of-network providers** will be covered at the in-network level of benefits.

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

As it applies to in-network coverage, you are covered for follow-up care only when your **health professional** provides the care or coordinates it. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency

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

In case of an urgent condition

If you need care for an **urgent condition**, you should first seek care through your **health professional**. If your **health professional** is not reasonably available to provide services, you may access urgent care from an **urgent care facility**.

5. Specific conditions

Autism spectrum disorder

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

Eligible health services include the services and supplies provided by a **health professional** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **health professional** orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

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

Important note: Applied behavior analysis requires **precertification** by **Aetna**. The **network provider** is responsible for obtaining **precertification**. You are responsible for making sure that **precertification** is obtained if you are using an **out-of-network provider**. **Precertification** can be requested by either you or your **out-of-network provider**.

Birthing center and physician services

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

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

Eligible health services also include charges made by:

- An operating **health professional** for:
  - Delivery
  - Pre- and post-natal care
  - Administration of an anesthetic
- A **physician** for administering an anesthetic (other than a local anesthetic)

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic equipment, supplies and education

Eligible health services include:

- Services
  - Foot care to minimize the risk of infection
- Supplies
  - Diabetic needles, syringes and pens
  - Test strips for blood glucose, ketone and urine monitoring, including visually readable strips
  - Injection aids
  - Blood glucose calibration liquid
  - Lancet devices and kits

- Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

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

Family planning services – other

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

- Voluntary sterilization for males
- Abortion

Exclusions

Your plan does not cover the following under this section:

- Reversal of voluntary sterilization procedures, for males and females, including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Jaw joint disorder treatment

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

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

Maternity and related newborn care

Eligible health services include prenatal and postpartum care and obstetrical services. This also includes complications of pregnancy. Coverage for a newborn child will be the same as child's mother for no less than 21 days.

After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **health professional**, with the consent of the mother, discharges the mother or newborn earlier
- Services and supplies needed for circumcision by a **provider**

Exclusions

Your plan does not cover the following under this section:

- Any services and supplies related to births that take place in:
  - The home, except when determined by the attending **health professional** to be a low-risk delivery
  - Any other place not licensed to perform deliveries

Mental health treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies including **prescription drugs**, 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**, or in a home setting, including:
  - Office visits to a **provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation or **store and forward technology**)
  - Individual, group and family therapies for the treatment of mental health
  - 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**, other **health professional** or **behavioral health provider**
    - **Intensive outpatient program** provided in a facility or program for mental health treatment provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **health professional** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Electro-convulsive therapy (ECT)
    - Mental health injectables
    - Transcranial magnetic stimulation (TMS)
    - Psychological testing
    - Neuropsychological testing
    - 23 hour observation

Exclusions

Your plan does not cover the following under this section:

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
  - **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance

that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
- Pathological gambling, kleptomania, pyromania
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Substance related disorders treatment

Eligible health services include the treatment of **substance abuse** provided by a **hospital**, **psychiatric hospital**, **residential treatment facility,** approved treatment program (certified by the Department of Social and Health Services), or **health professional** as follows:

- **Inpatient room and board**, at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

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

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital** or **residential treatment facility** or in a home setting, including:
  - Office visits to a **provider** such as a **psychiatrist**, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation or **store and forward technology**)
  - Individual, group and family therapies for the treatment of **substance abuse**
  - Other outpatient substance abuse treatment such as:
    - Outpatient **detoxification**
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**, other **health professional** or **behavioral health provider**
    - Ambulatory **detoxification** which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **health professional** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications

- Treatment of withdrawal symptoms
- Substance use disorder injectables
- 23 hour observation

Exclusions

In addition to the general exclusions shown under the *Exclusions* section your plan does not cover the following under this section:

- Services related to caffeine and tobacco (except where described in the *Eligible health services under your plan – Preventive care and wellness* section)
- Halfway houses, sober living arrangements, and three-quarter houses

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician,** or a dentist and **hospital**:

- Non-surgical treatment of infections or diseases
  - **Surgery** needed to:
    - Treat a fracture, dislocation, or wound
    - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues
    - Cut into gums and tissues of the mouth; this is only covered when not done in connection with the removal, replacement or repair of teeth
    - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- **Hospital** services and supplies received for a **stay** required because of your condition
- Dental work, **surgery** and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth after an **injury**
  - The first crown needed to repair each damaged tooth after an **injury**
  - An in-mouth appliance used in the first course of orthodontic treatment after an **injury**
- Dental work due to accidental **injuries** and other trauma:
  - Oral **surgery** and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the **injury**.
  - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
  - If a child needs oral **surgery** as the result of accidental **injury** or trauma, **surgery** may be postponed until a certain level of growth has been achieved.
- Removal of tumors and cysts requiring pathological examination
- Fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy
- Oral **surgery** and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will

improve function
- Related dental 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 preposition teeth

Exclusions
Your plan does not cover the following under this section:
- Dental implants

Reconstructive surgery and supplies
Eligible health services include all stages of reconstructive **surgery** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it even with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function

Transplant services
Eligible health services include organ transplant services provided by a **physician** and **hospital**.

Organ means:
- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities
The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:
- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A non-**IOE facility**

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

Travel and lodging expenses
Eligible health services include travel and lodging expenses for the **IOE** patient and a companion to travel between the **IOE** patient's home and the **IOE facility**. **Eligible health services** will be reimbursed by the plan and include coach class round-trip air, train, or bus travel and lodging costs.

Exclusions

Your plan does not cover the following under this section:

- 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, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing **illness**
- Travel and lodging expenses for transplants that are not obtained at an **IOE facility**

Treatment of infertility

Basic infertility

Eligible health services include seeing a **network provider**:

- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

Exclusions

Your plan does not cover the following under this section:

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

6. Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

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

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

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

Genetic and prenatal testing

Eligible health services include:

- Genetic testing to establish a molecular diagnosis of an inheritable disease, including:
  - One test per lifetime by a health **professional** or lab
  - One test per lifetime by a genetic counselor to read the test results and provide treatment options
- Prenatal testing of a fetus, including screenings and other diagnostic tests, if they are performed:
  - When you are pregnant, to detect congenital or inherited disorders of the fetus
  - By a **hospital**, diagnostic lab facility or **health professional**

Chemotherapy

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

Outpatient infusion therapy

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

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **health professional** in the office
- A home care **provider** in your home

You can access the list of preferred infusion locations by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient prescription drugs rider. You can access the list of **specialty prescription drugs** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card. You can also determine if coverage is under the outpatient prescription drugs rider or this booklet-certificate.

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

Exclusions

Your plan does not cover the following under this section:

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer
- Drugs that are included on the list of **specialty prescription drugs** as covered under the outpatient prescription drugs rider
- Enteral nutrition
- Blood transfusions and blood products

Outpatient radiation therapy

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

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

Specialty prescription drugs

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

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **health professional** in the office
  - A home care **provider** in your home
- Listed on our **specialty prescription drug** list as covered under this booklet-certificate.

You can access the list of **specialty prescription drugs** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.

Certain injected and infused medications may be covered under the outpatient prescription drugs rider. You can access the list of **specialty prescription drugs** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card. You can also determine if coverage is under the outpatient prescription drugs rider or this booklet-certificate.

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

Exclusions

Your plan does not cover the following under this section:

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer
- Drugs that are included on the list of **specialty prescription drugs** as covered under the outpatient prescription drugs rider

Short-term cardiac and pulmonary rehabilitation services

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

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

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

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

Short-term rehabilitation services

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

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician** or other appropriate **health professional**

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

Outpatient cognitive rehabilitation, massage, physical, occupational, and speech therapy

Eligible health services include:

- 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

- Massage therapy, but only when it is provided by a **health professional** licensed to provide massage therapy, and:
  - The condition it is expected to improve has been diagnosed by a **health professional**, if making such a diagnosis is within the scope of their license
  - Is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**
- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness**, **injury** or **surgical procedure**
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness**, **injury** or **surgical procedure**
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness**, **injury** or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

Your therapy should include an ongoing, written plan of care from your **health professional**. This plan of care should include specific short-term and long-term goals. These goals allow your improvement to be measured in an objective way. Therefore, when we say "significantly improve" in this section, we mean that the goals in your plan of care are expected to result in clinically significant improvement.

Important note: See the *Short-term rehabilitation* section of the schedule of benefits for the cost share of the therapy visits. See the *Other health professional services* section of the schedule of benefits for your cost share for office visits, including evaluations.

Habilitation therapy services

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

Eligible health services include habilitation therapy services your **health professional** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician** or other appropriate **health professional**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **health professional**.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is

expected to develop any impaired function.

- Occupational therapy (except for vocational rehabilitation or employment counseling or services provided in an educational or training setting), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.
  (Speech function is the ability to express thoughts, speak words and form sentences)

Neurodevelopmental therapy

Eligible health services include rehabilitative and habilitative speech, physical or occupational therapy, but only if it is expected to:

- Restore or improve speech or a body function
- Develop speech or a body function that was lost or delayed because of an **illness** or because of a condition you had when you were born
- Maintain speech or a body function that would get worse because of an **illness** or because of a condition you had when you were born

7. Other services

Acupuncture

Eligible health services include acupuncture. The service performed must be within the scope of an East Asian Medicine Practitioner's license, as regulated by Washington state law.

Ambulance service

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

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

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

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

Exclusions

Your plan does not cover the following under this section:

- **Ambulance** services for routine transportation to receive outpatient or inpatient services

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Life-threatening disease or condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

An "approved clinical trial" must satisfy one of the following:

- Federally funded trials. The study or investigation is approved or funded by one or more of the following:
  - The National Institutes of Health (NIH)
  - An NIH cooperative group or center (a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program)

- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - The Department of Veterans Affairs
  - The Department of Defense
  - An institutional review board of a Washington institution that has a multiple project contract approval by the Office of Protection for the Research Risks of NIH

Exclusions
Your plan does not cover the following under this section:
- Services and supplies related to data collection and analysis needs and are not used in your direct clinical management
- Services and supplies provided by the trial sponsor without charge to you
- The experimental item, device, or service itself
- Services and supplies that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

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

Coverage includes:
- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Exclusions
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. Your plan does not cover the following under this section:
- Whirlpools
- Portable whirlpool pumps
- Massage tables
- Sauna baths
- Message devices (personal voice recorder)
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Experimental or investigational therapies

Eligible health services include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** only when you have cancer or a **terminal illness** and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- Published, peer-reviewed scientific evidence indicates that you may benefit from the treatment.
- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The study has been approved by an Institutional Review Board that will oversee the investigation.
- The study is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The study conforms to standards of the NCI or other, applicable federal organization.
- The study takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Hearing exams

Eligible health services include hearing care that includes hearing exams.

Nutritional supplements

Eligible health services include amino acid modified preparations, dietary specialized formulas and low protein modified food products for the treatment of inherited metabolic diseases including phenylketonuria and eosinophilic gastrointestinal disorder.

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 intended to be used under the direction of a **health professional** for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

Exclusions

Your plan does not cover the following under this section:

- Any food item, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered above

Orthotic devices

Eligible health services include mechanical supportive devices ordered by your **health professional** for the treatment of weak or muscle deficient feet. This includes foot orthotics, orthopedic shoes and supportive devices of the feet.

Prosthetic devices

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

Prosthetic device means:

- A medical device, including wigs, that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of **illness** or **injury** or congenital defects

Coverage includes:

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

Exclusions

Your plan does not cover the following under this section:

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

Spinal manipulation

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

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

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there about the exclusions that apply to those specific health care services and supplies.

In this section we tell you about the general exclusions. We explain what general services and supplies are not covered under the entire plan. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

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

General exclusions

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

Examples of these are:

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

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

Cosmetic services and plastic surgery

- Any treatment, **surgery** (**cosmetic** or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This **cosmetic** services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible.

Counseling

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

Court-ordered services and supplies

- Court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding unless our medical director or designee determines the treatment to be **medically necessary**.

Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care, 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, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered in the *Eligible health services under your plan - Oral and maxillofacial treatment* section. Dental services related to:

- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

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

Early intensive behavioral interventions

Examples of those services are:

- Early intensive behavioral interventions (LEAP, TEACCH. Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

Educational services

Examples of those services are:

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

Examinations

Any health examinations needed:

- Because a third party requires the exam (examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract)
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under **experimental** or investigational therapies or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

Facility charges

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes or fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies creams, ointments, and arch supports, shoe inserts, ankle braces, guards, protectors
  - Routine pedicure services, such as such as routine cutting of nails, when there is no **illness** or **injury** in the nails

Growth/Height care

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

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy service*s section.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Compresses

  – Other devices not intended for reuse by another patient

Obesity (bariatric) surgery and weight management

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer
- Outpatient **prescription** or non-**prescription drugs** and medicines as covered under your outpatient prescription drugs rider
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient prescription drugs rider

Personal care, comfort or convenience items

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

Routine exams

- Routine physical exams provided by an **out-of-network provider**, routine dental exams, and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member, where you would not be charged in the absence of insurance

Services, supplies and drugs received outside of the United States

- Non-emergency medical services, non-emergency 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 booklet-certificate. Emergency **prescription drugs** received outside of the United States are covered.

Sexual dysfunction and enhancement

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery**, **prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ provided however, this exclusion does not apply to services for treatment of gender identity disorder or gender dysphoria
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Store and forward technology

- Services for which there is no related office visit with the **provider**
- Services for which **Aetna** does not have an agreement with the **provider**
- Services using:
  - Telephone calls that are audio only
  - Faxes
  - Emails
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine providers**
- Services that are not provided in real time
- Services that are not interactive, including:
  - Telephone calls that are audio only
  - Faxes
  - Emails
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Sensory or auditory integration therapy

Tobacco cessation except as specifically provided in the *Eligible health services under your plan* section.

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF)

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, except to the extent coverage is required by applicable laws

Vision care

- Routine vision exam provided by an ophthalmologist or optometrist
- Vision care services and supplies, including:
  - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
  - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

Wilderness Treatment Programs

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

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Who provides the care

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

Network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- Urgent care – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section

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

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

Your PCP

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

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

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

How do you choose your PCP?

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

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

What will your PCP do for you?

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

Your **PCP** can also:

- Order lab tests and radiological services
- Prescribe medicine or therapy

- Arrange a **hospital stay** or a **stay** in another facility

Out-of-network providers

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

- Paying your out-of-network **deductible**
- Paying your out-of-network coinsurance
- Paying any charges over our **recognized charge**
- Submitting your own claims
- Ensuring **precertification** is obtained by either you or your **out-of-network provider**

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

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

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

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

	If you are a new enrollee and your provider is an out-of-network provider	**When your provider stops participation with Aetna**
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the number on your ID card.	You or your **provider** should call us for approval to continue any care.
Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.

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

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

What the plan pays and what you pay

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

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

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

The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

And then

- The plan and you share the expense. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/coinsurance.**

And then

- The plan pays the entire expense after you reach any **maximum out-of-pocket limit**.

When we say "expense" in this general rule, we mean the **negotiated charge** for a **network provider**, and **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

Important exceptions – when you pay all

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

- When you get a health care service or supply that is not **medically necessary.** See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, your **health professional** requested it, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

Where your schedule of benefits fits in

How your deductible works

Your **deductible** is the amount you need to pay for **eligible health services** per **plan year** before your plan begins to pay for **eligible health services**. Your schedule of benefits shows the **deductible** amounts for your plan.

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for **eligible health services** after you have paid your **deductible**, if applicable. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **eligible health services**.

You will pay the network **copayment/coinsurance** when you receive **eligible health services** from any **PCP**.

How your maximum out-of-pocket limit works

You will pay your **deductible** and **copayments/coinsurance** up to the **maximum out-of-pocket limit** for your plan. Your 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 benefits** for the remainder of that **plan year**.

Important note: See the schedule of benefits for any **deductibles, copayments/coinsurance, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

When you disagree - claim decisions and appeals procedures

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

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

Claim procedures

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

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from us • The claim form will provide instructions on how to complete and where to send the form(s)	• You must send us notice and proof as soon as reasonably possible • If you are unable to complete a claim form, you may send us: − A description of services − Bill of charges − Any medical documentation you received from your **provider**
Proof of loss (claim)	• A completed claim form and any additional information required by us	• You must send us notice and proof as soon as reasonably possible
Benefit payment	• Written proof must be provided for all benefits • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid promptly after the receipt of proof of loss	• Benefits will be paid as soon as the necessary proof to support the claim is received

Types of claims and communicating our claim decisions

You or your **provider** is required to send us a claim in writing. If you or your dependent goes to a network provider, the **network provider** will file the claims. When you go to an **out-of-network provider**, you will have to file the claims. You can request a claim form from us. We will review that claim for payment to the **provider** or to you as appropriate.

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

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

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

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

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

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

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

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

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

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

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	Within 48 hours or Within 1 business day for an emergency request	5 calendar days	30 calendar days	No later than 24 hours for urgent request* or 5 calendar days for non-urgent request
Request for Extension	Not applicable	Within 5 calendar days	15 calendar days	Not applicable
Additional information request (us)	24 hours	5 calendar days	30 calendar days	Not applicable
Response to receipt of additional information request (you)	48 hours	30 calendar days	45 calendar days	Not applicable

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

Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** if you go to a **network provider** and the **recognized charge** if you go to an **out-of-network provider**, except for your share of the costs.

But sometimes we pay only some of the claim. And sometimes we may deny payment or service entirely.

We may sometimes:

- Deny
- Change
- Reduce, or
- Terminate

your

- Health care services or benefits
- Authorization relating to such services or benefits, or
- Coverage or payment for the health care services or benefits

Such actions are called “adverse benefit determinations.” Other actions that are also called “adverse benefit determinations” include:

- We do not authorize a **stay** in a **hospital** or other facility
- We decide that you or your dependents were not eligible for the coverage when you received the services
- We decide that you have reached your benefit maximums
- Your health care services are excluded, not covered or limited in some way
- We rescind your coverage entirely

Reasons for adverse benefit determinations may be:

- The results of utilization review activities
- The health care services are **experimental or investigational**
- The health care services are not **medically necessary**

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

The difference between a grievance and an appeal

A grievance

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

An appeal

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us by calling the number on your ID card.

Appeals of adverse benefit determinations

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

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

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

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

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

Urgent care or pre-service claim appeals

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

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at

your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

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

<table>
<tr><th>Type of notice</th><th>Urgent care claim</th><th>Pre-service claim</th><th>Post-service claim</th><th>Concurrent care claim</th></tr>
<tr><td>Appeal determinations at each level (us)</td><td>24 hours, but no longer than 72 hours</td><td colspan="2">14 days, or
20 days for an experimental or investigational treatment. We will let you know within 72 hours that we have received your appeal.</td><td rowspan="2">As appropriate to type of claim</td></tr>
<tr><td>Extension to respond (us)</td><td>None</td><td colspan="2">16 additional days, if we notify you and provide a reason. We will get your written permission if we need more time beyond the 16 additional days.</td></tr>
</table>

Exhaustion of appeals process

In most situations you must complete the one level of appeal with us before you can pursue arbitration, litigation or other type of administrative proceeding.

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

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally. See the *How to contact us for help* section for details on how to reach us.
- We did not follow all of the claim determination and appeal requirements of Washington or of the Federal Department of Health and Human Services. You will not be able to proceed directly to external review if the violation was:
  – Minor and not likely to influence a decision or harm you
  – For a good cause or beyond our control
  – Part of an ongoing, good faith exchange between you and us

At any time you may contact the Washington Office of the Insurance Commissioner at 800-562-6900 to request an investigation of a grievance or appeal.

External review

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

You have a right to external review if:

- Our claim decision involved medical judgment
- We decided the service or supply is not **medically necessary** or not appropriate
- We decided the service or supply is **experimental or investigational**

- You have received an adverse determination

The notice of adverse benefit determination or final adverse benefit determination we send you will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 180 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

Aetna will:

- Contact the ERO that will conduct the review of your claim
- Notify you of the name of the ERO and its contact information within one day of selecting the ERO
- Send required information, including the information you sent us, to the ERO within 3 business days from the date we received the notice of your request for an external review

The ERO will:

- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review
- Will accept additional written information from you for up to five business days after the ERO accepts its assignment
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 30 calendar days of the date we receive your request form and all the necessary information

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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 30 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

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

There are two scenarios when you may be able to get a faster external review. If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

For initial adverse determinations

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

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

For final adverse determinations

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

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

Important note: You can request a review of a denied claim by the WEA Board of Directors, or its appointed Benefit Services Advisory Board (BSAB). A BSAB review is in addition to any **Aetna** appeal procedures. You may request a BSAB review at any time. You do not need to exhaust the Aetna appeal process first. For more information on the BSAB review process, call Aon Hewitt at 206-467-4646.

Recordkeeping

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

Fees and expenses

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

Coordination of benefits

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

Key terms

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

Allowable expense means:

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

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

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

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid.
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

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

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

<table>
<tr><th>If you are covered as a:</th><th>Primary plan</th><th>Secondary plan</th></tr>
<tr><td>Non-dependent or dependent</td><td>The plan covering you as an employee or retired employee</td><td>The plan covering you as a dependent</td></tr>
<tr><td>Exception to the rule above when you are eligible for Medicare</td><td colspan="2">If you or your spouse has Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us:
▪ Online: Log on to your Aetna secure member website at www.aetna.com
▪ By phone: Call the number on your ID card</td></tr>
</table>

COB rules for dependent children		
Child of: • Parents who are married or living together	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the **calendar year**. *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*. *Same birthdays--the plan that has covered a parent longer is primary
Child of: • Parents separated or divorced or not living together • With court-order	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.
Child of: • Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody	Primary and secondary coverage is based on the birthday rule.	
• Child covered by: Individual who is not a parent (i.e. stepparent or grandparent)	Treat the person the same as a parent when making the order of benefits determination. See *Child of* content above	
Child of: • Parents separated or divorced or not living together and there is no court-order	The order of benefit payments is: • The plan of the custodial parent pays first • The plan of the spouse of the custodial parent (if any) pays second • The plan of the noncustodial parents pays next • The plan of the spouse of the noncustodial parent (if any) pays last	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the

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

How are benefits paid?

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

How COB works with Medicare

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

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age
- Disability
- End stage renal disease

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

Who pays first?

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

This plan is secondary to Medicare in all other circumstances.

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

Dual WEA coverage

If you are covered under more than one WEA Select Medical plan (plans 2, 3, 5, EasyChoice A, EasyChoice B or Basic):

- Any required **deductibles** and **copayment**/**coinsurance** are waived
- **Covered benefits** are provided at 100% of the **negotiated charge** or **recognized charge**
- Any dollar limit benefit maximums are doubled
- Any visit limit benefit maximums are not doubled

A service may be covered under one plan, but excluded under the other. In that case, the **covered benefit** will be provided at 100% of the **negotiated charge** or **recognized charge**, up to any benefit maximum, on the plan that covers the service.

Covered benefits will be provided under the COB provisions described earlier in this section if that results in a higher payment.

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.

- **Online:** Log on to your **Aetna** secure member website at www.aetna.com
- **By phone:** Call the number on your ID card

Right to receive and release needed information

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

Right to pay another carrier

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

Right of recovery

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

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

Important note: If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your **provider** should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within 30 calendar days.

All health plans have timely claim filing requirements. If you or your **provider** fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan, you should promptly report to your **providers** and plans any changes in your coverage.

When coverage ends

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

When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage including when you move out of the **service area**
- Your employment ends
- You do not make any required contributions
- We end your coverage
- You become covered under another medical plan offered by your employer
- You have exhausted your overall maximum benefit under your medical plan

When coverage may continue under the plan

Your coverage under this plan will continue if:

Your employment ends because of **illness, injury**, as agreed to by your employer and us	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your employer and we agree to do so and as described below: • Your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
Your employment ends because of a: • Temporary lay-off • Temporary leave of absence • Sabbatical, or • Other authorized leave as agreed to by your employer and us	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your employer and we agree to do so and as described below: • Your coverage will stop on the last day of the month in which the lay-off or leave of absence occurred
Your employment ends because: • Your job has been eliminated • You have been placed on severance, or • This plan allows former employees to continue their coverage	You may be able to continue coverage. See the *Special coverage options after your coverage ends* section.
Your employment ends because of a: • Paid or unpaid medical leave of absence • Leave of absence that is not a medical leave of absence, or • Military leave of absence	If **premium** payments are made for you, you may be able to continue coverage under the plan as long as your employer and we agree to do so and as described below: • Your coverage may continue until stopped by your employer

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

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- You do not make the required contribution toward the cost of dependents' coverage

Why would we end you and your dependents coverage?

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

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

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

When will we send you a notice of your coverage ending?

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in "Why we would end your coverage").

Your coverage will end on either the date you stop active work, or the day before the first **premium** contribution due date that occurs after you stop active work.

Special coverage options after your coverage ends

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?

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 time period is determined by the qualifying event. You and your dependents, if any, will receive notice of your COBRA rights within 90 days of your active employment. Your employer will notify us if a qualifying event occurs but sometimes you and your dependents, if any, are responsible for notifying your employer of several of the events, such as divorce or separation. Talk with your employer if you have questions about this.

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

How you enroll in COBRA

If COBRA applies to you, the employer has 14 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You enroll by sending in an application and paying the premium. You have 60 days from the date you would lose coverage or when the notice is provided, whichever is later, to decide if you want to enroll. Please call your plan administrator immediately to be sure of your timeframe. You need to send your application and pay the premium. If this is completed on time, you have enrolled in COBRA.

When your first premium payment is due

Your first premium payment must be made within 45 days after the date of the COBRA election.

Continuation of coverage for other reasons

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

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

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

Benefits are extended 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
- When **hospital** or **skilled nursing facility** benefits are exhausted
- 12 months of coverage

How can you extend coverage for your disabled child beyond the plan age limits?
You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:
- Is not able to be self-supporting because of mental or physical disability, and
- Depends chiefly on you for support and maintenance.

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

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year after 2 years from the date your child reached the maximum age. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage during a strike, lockout or other labor dispute?
You have a right to extend coverage for you and your dependents even if you are absent from work because of a strike, lockout or other labor dispute if:
- You were covered on the date you stopped working
- You paid your **premium** when due

You can continue your coverage for up to 6 months if you pay your **premiums** to your employer. Your employer will send your payment to Alight. Call the number on your ID card to get the process started. Your coverage will continue until:
- You go to work full-time for another employer
- You do not make the required **premium** payments
- The labor dispute ends, or
- The 6 months continuation period ends

Your **premium** payment will be the same rate you were paying on the date you stopped working. But, if the **premium** amount your employer has to pay changes during the time you are extending your coverage, your **premiums** will also change.

How you can extend coverage during a leave of absence?

If you are on an official leave of absence or sabbatical, coverage for you and any dependents may be extended for up to 18 months. The leave of absence time period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time, or if you terminate coverage at any time during the leave of absence, you must reenroll on the plan within 30 days of your return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during the leave, you will immediately become eligible for COBRA. To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage ends under the leave of absence provision.

A district-approved leave beyond 18 months does not entitle you or any dependents to extend coverage under this leave of absence provision. If you do not return to work after the leave or if another consecutive district-approved leave is granted without another period of active employment, you and any dependents may be eligible for an additional 18 months of continued coverage through COBRA. The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provision and up to 18 months of COBRA continuation coverage.

Additional coverage under this provision may be elected if you return to work and are granted further official leaves of absence or sabbaticals. For example:

- You are granted a leave of absence and are no longer actively at work as of March 20
- Your active work results in fringe benefit dollars for March, which pay for April benefits
- You will receive sick leave through the district leave-sharing plan for 2 months

In the above example, the 18 month leave of absence coverage period would officially begin on May 1, because April is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18 months, at which time the district would need to provide you notice of access to COBRA continuation for 18 additional months (total 36 months). If the above leave of absence started before the March payroll cutoff for benefits, the leave period would begin April 1.

Dependents can only be added during a leave of absence period when they qualify to enroll. See the *Who the plan covers* section.

Limited-time continuation

Your coverage may be extended, if you and your dependents are no longer eligible for coverage. Coverage can continue for up to 3 months. You must make your **premium** payments to continue. Call the number on your ID card to get the process started.

This limited-time coverage is not available if:

- You are eligible for COBRA
- Your **group policy** ends
- Your employment ends due to gross misconduct or the coverage ends due to fraud or intentional misrepresentation

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to other federal laws and state laws that apply. You and we will interpret it according to these laws. Interpretation of this booklet-certificate is subject to the *When you disagree - claim decisions and appeals procedures* section when we administer your coverage.

How we administer this plan

We apply policies and procedures we've develop 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 insurance policy. This document may have endorsements too. Under certain circumstances, we or your policyholder 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 **Aetna** may waive a requirement of your plan. No other person – including your employer or **provider** – can do this.

If a service cannot be provided to you

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

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

Legal action

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

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

Physical examinations and evaluations

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

Records of expenses

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

Things that would be important to keep are:
- Names of **health professionals**, dentists and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

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

Intentional deception
If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your 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 of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.
- We will give you 30 days advanced written notice of any rescission of coverage
- You have the right to an **Aetna** appeal
- You have the right to a third party review conducted by an independent ERO

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 in accordance with law. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this **group policy.** This may include:
- The benefits due
- The right to receive payments
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this **group policy**

To request assignment you must complete an assignment form. The assignment form is available from **Aetna**. The completed form must be sent to **Aetna** for consent. See the *How to contact us for help* section for details on how to reach us.

Financial sanctions exclusions
If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, **Aetna** companies 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 it is permitted under a written license from the Office of Foreign Asset Control (OFAC). For more information visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Premium contribution
This plan requires you to make **premium** contribution payments. If payments are made through a payroll deduction with the employer, the employer will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

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

When you are injured
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. After you are fully compensated for your loss, we are entitled to that money, up to the amount we pay for your care. We have that right no matter who the money comes from – for example, the other driver, your employer or another insurance company.

To help us get paid back, you are doing four things now:
- You are agreeing to repay us from money you receive because of your **injury** after you are fully compensated for your loss.
- You are giving us a 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.
- You are agreeing to cooperate with us so we can get paid back in full. For example, you'll tell us within 30 days of when you seek money 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.
- You are agreeing to provide us notice of any money you will be receiving before pay out, or within 5 days of when you receive the money.

We don't have to reduce the amount we're due for any reason, even to help pay your lawyer or pay other costs you incurred to get a recovery except that we will help share in the attorney fees that you incurred to recover the money.

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 **providers'** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call the number on your ID card.
When you accept coverage under this plan, you agree to let your **providers** share information with us.
We need information about your physical and mental condition and care.

Effect of benefits under other plans

Effect of prior coverage – transferred business

Prior coverage means:

- Any plan of group coverage that has been replaced by coverage under part or all of this plan.
- The plan must have been sponsored by your employer or the policyholder (e.g., transferred business).
- If you are eligible, the replacement can be complete, or in part for your eligible class. Any such plan is prior coverage if provided by another **group policy** or any benefit section of this plan.

If your coverage under any part of this plan replaces any prior coverage any benefits provided under such prior coverage may reduce benefits payable under this plan See the *General coverage provisions* section of the schedule of benefits.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

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

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

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

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand-name by the company that manufactures it, usually by the company which develops and patents it.

Calendar year
A period of 1 year beginning on January 1st and ending on December 31st.

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

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

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

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:

- They are **medically necessary**
- You received **precertification**, if required

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

Deductible
The amount you pay for **eligible health services** per **plan year** before your plan starts to pay as listed in the schedule of benefits.

Dental provider
Any individual legally qualified to provide dental services or supplies, including a denturist.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:
- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

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

Directory
The list of **network providers** for your plan. The most up-to-date **directory** for your plan appears at www.aetna.com. When searching, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain **Aetna** plans.

Durable medical equipment (DME)
Equipment and the accessories needed to operate it, that is:
- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage
The date you and your dependent's coverage begin under this booklet-certificate as noted in **Aetna's** records.

Eligible health services
The health care services and supplies and prescription drugs listed in the *Eligible health services under your plan* section of this booklet-certificate or in the outpatient prescription drugs rider and not carved out or limited in the *Exclusions* section or in the schedule of benefits**.**

Emergency admission
An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services.**

Emergency medical condition
A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature that, if you don't get immediate medical care it could result in:
- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

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

Experimental or investigational

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

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

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The group application
- The **group policy**
- The booklet-certificates
- The schedules of benefits
- Any riders and endorsements to the **group policy** the booklet-certificate, and the schedule of benefits

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public within the scope of his or her license, certification or authorization. For example, **physicians**, nurses, physical therapists, licensed midwives and massage therapists.

Home health care agency

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

Home health care plan

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

Hospice care

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

Hospice care agency

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

Hospice care program
A program prescribed by a **health professional** to provide **hospice care** and supportive care to their families.

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

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

Hospital does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility** for **substance abuse**
- **Residential treatment facility** for **mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

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

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

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

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

Intensive Outpatient Program (IOP)
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed

or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

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

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy

An establishment where **prescription drugs** are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments**/**coinsurance**, including any **deductible**, to be paid by you or any covered dependents per **plan year** for **eligible health services**.

Medically necessary/Medical necessity

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, injury**, disease or its symptoms, and that 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
- Consistent with the standards set forth in policy issues involving clinical judgment

Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/Morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

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

Negotiated charge

For health coverage, this is either:

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

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

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

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

Network provider

A **provider** listed as an Open Choice® **network provider** in the **directory** for your plan.

Out-of-network provider

A **provider** who is not a **network provider.**

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

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

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

Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice, specifically, doctors of medicine or osteopathy.

Plan year
A 14-month period which defines your maximum cost sharing amounts. The schedule of benefits shows you the beginning and ending dates of the **plan year** that applies to your plan.

Precertification, precertify
A requirement that you or your **health professional** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage. If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You or your **health professional** may request a review of the **precertification** decision. See the *When you disagree - claim decisions and appeals procedures* section.

Premium
The amount you or your employer is required to pay to **Aetna** to continue coverage.

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

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

Primary care physician (PCP)
A **physician** who:
- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist or a pediatrician
- Is shown on **Aetna**'s records as your **PCP**

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

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

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

Recognized charge

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

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

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	105% of the Medicare allowable rate
Services of **hospitals** and other facilities	140% of the Medicare allowable rate
Prescription drugs	110% of the average wholesale price (AWP)
Important note: If the **provider** bills less than the amount calculated using the method above, the **recognized charge** is what the **provider** bills.	

Recognized charge does not apply to involuntary services.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
  - Not available from a **network provider**
  - **Emergency services**

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

Our reimbursement policies

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

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service

- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies are based on our review of:

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

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

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

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating **mental disorders**:

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

Residential treatment facility (substance abuse)

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

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

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

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

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

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

Service area

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

Skilled nursing facility

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

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

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- **Custodial care** services
- Ambulatory care

- Part-time care services

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

Skilled nursing services

Services provided by an **R.N**. or **L.P.N.** within the scope of his or her license.

Specialist

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

Specialty prescription drugs

These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling the number on your ID card or by logging on to your **Aetna** secure member website at www.aetna.com. The list also includes biosimilar **prescription drugs**.

Specialty pharmacy

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

Stay

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

Step therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of **step therapy** drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.aetna.com.

Store and forward technology

This means that your medical information is shared with a **provider**, but not in real time. But, there are some rules:

- You must have already had a related office visit with the referring **provider**
- We must have an existing agreement with the **provider** to pay for the service
- You and the **provider** must be in different locations
- The **provider** must use the information to diagnose or manage your medical condition

Store and forward technology does not include:

- Telephone calls (audio only)
- Faxes
- Emails

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a **mental disorder**

that are a focus of attention or treatment, or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

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, or otherwise physically changing body tissues and organs.

Telemedicine

Health care services provided to you by a **provider** using interactive audio and video technology. This means that you and the **provider** are in different locations, but are communicating in real time. The **provider** must be diagnosing, consulting or treating your medical or behavioral health condition.

Telemedicine does not include:

- Telephone calls (audio only)
- Faxes
- Emails

Terminal illness

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

Urgent care facility

A facility licensed as a medical facility by applicable state and federal laws to treat an **urgent condition.**

Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

Discount programs

Discount arrangements

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

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

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

Wellness and other incentives

We may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as an **Aetna** member through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to **copayment**/**coinsurance** or **deductible** amounts
- **Premium** discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

Open Choice®
Preferred Provider Organization (PPO)

Medical Expense Insurance Plan
Schedule of benefits

Prepared exclusively for:

Policyholder:	Washington Education Association
Policyholder number:	285730
Group policy number:	285730
Group policy effective date:	November 1, 2017
Schedule of benefits:	6B Select Basic Plan
Original effective date:	November 1, 2017
Plan effective date:	November 1, 2018
Plan issue date:	November 27, 2018
Plan year	From: November 1, 2018 To: December 31, 2019

Underwritten by Aetna Life Insurance Company in the state of Washington

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with any **deductibles**, **copayments/coinsurance** and limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from **network providers**
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **copayment/coinsurance** amounts under your plan.
- You are responsible to pay any **deductibles** and **copayments**.
- Any **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- Sometimes we don't show a specific cost share for a benefit. Instead we say, "Covered according to the type of benefit and the place where the service is received." That means your cost share will depend on the exact care you get and who provides it. For example, if you receive services for diabetes from a **specialist** in their office, you will pay the cost share listed in *Specialist office visits*. If you receive services for diabetes during a **hospital stay**, you will pay the cost share listed in *Hospital care*.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- At the beginning of this schedule you will find detailed explanations about any:
  - **Deductible**
  - **Copayments/Coinsurance**
  - **Maximum out-of-pocket limits**
  - Maximums

Important note: All **covered benefits** are subject to the **plan year deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact us by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy.** This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Copayments/Coinsurance**
- **Maximum out-of-pocket limits**
- Maximums

Deductible provisions
Eligible health services that are subject to the **deductible** do not include **prescription drug eligible health services** provided under the outpatient prescription drugs rider.
Eligible health services applied to the out-of-network **deductibles** will not be applied to satisfy the in-network **deductibles**. **Eligible health services** applied to the in-network **deductibles** will not be applied to satisfy the out-of-network **deductibles**.
Individual This is the amount you owe for in-network and out-of-network **eligible health services** each **plan year** before the plan begins to pay for **eligible health services**. This **plan year deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the **plan year deductible**, this plan will begin to pay for **eligible health services** for the rest of the **plan year**. **Family** This is the amount you and your covered dependents owe for in-network and out-of-network **eligible health services** each **plan year** before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family **plan year deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the **plan year**. To satisfy this family **deductible** limit for the rest of the **plan year**, the combined **eligible health services** that you and each of your covered dependents incur towards the individual **plan year deductibles** must reach this family **deductible** limit in a **plan year**. When this occurs in a **plan year**, the individual **plan year deductibles** for you and your covered dependents will be considered to be met for the rest of the **plan year**.
Copayments
The specific dollar amount you have to pay for a health care service listed in the schedule of benefits.
Coinsurance
The specific percentage you and the plan have to pay for a health care service listed in the schedule of benefits.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Maximum out-of-pocket limit provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the outpatient prescription drugs rider.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/coinsurance** and **deductibles** for **eligible health services** during the **plan year**. This plan has an individual and family **maximum out-of-pocket limit**.

Individual
Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the **plan year** meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge or recognized charge** for **covered benefits** that apply toward the limit for the rest of the **plan year** for that person.

Family
Once the amount of the **copayments/coinsurance** and **deductibles** you and your covered dependents have paid for **eligible health services** during the **plan year** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the **plan year** for all covered family members.

Certain costs that you incur do not apply toward the in-network **maximum out-of-pocket limit**. These include:

- Charges, expenses or costs in excess of the **recognized charge** for out-of-network services
- All costs for non-covered services
- Any **precertification** penalty

Maximums

This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers**, unless we state otherwise.

These maximums are for a 12 month period, beginning on November 1. Your maximum limits will start over on November 1 of each year.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of 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 **plan year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features	Deductible/ Maximums	
	In-network coverage*	**Out-of-network coverage***
Deductible		
You have to meet your **plan year deductible** before this plan pays for benefits.		
Individual	$2,100 per **plan year**	$2,500 per **plan year**
Family	$4,200 per **plan year**	$5,000 per **plan year**
Maximum out-of-pocket limit		
Individual	$6,600 per **plan year**	None
Family	$13,200 per **plan year**	None
Deductible waiver		
The **plan year deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives • For **PCP** and **specialist** services if a **copay** applies		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
1. Preventive care and wellness		
Routine physical exams		
Performed at a **health professional's** office	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Covered persons through age 21: Maximum age and visit limits per 12 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **health professional** or **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not covered
Covered persons age 22 and over: Maximum visits per 12 months	1 visit	Not covered
Preventive care immunizations		
Performed in a facility or at a **health professional's** office	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Limited to:	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **health professional** or **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not covered

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Well woman preventive visits, routine gynecological exams (including pap smears)		
Performed at a **health professional's** office, such as an obstetrician (OB), gynecologist (GYN) or OB/GYN	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Not covered
Preventive screening and counseling services		
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Obesity and/or healthy diet counseling maximums		
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older)	26 visits* (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	Not covered
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Misuse of alcohol and/or drugs maximums		
Maximum visits per 12 months	5 visits*	Not covered
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Use of tobacco products maximums		
Maximum visits per 12 months	8 visits*	Not covered
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Sexually transmitted infection counseling maximums		
Maximum visits per 12 months	2 visits*	Not covered
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
Genetic risk counseling for breast and ovarian cancer maximums		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not covered
Routine cancer screenings (applies whether performed at a health professional's office or a facility)		
Routine cancer screenings	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **health professional** or **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **health professional** or **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
***Important note:** Any lung cancer screening that exceeds the lung cancer screening maximum above is covered under the *Outpatient diagnostic testing* section.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Performed at a **health professional's** office or a facility	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Lactation counseling services maximum visits per 12 months, in either a group or individual setting	6 visits*	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered as office visits under *Physicians and other health professionals*.		
Breast feeding durable medical equipment		
Breast pump supplies and accessories	100% (of the **negotiated charge**) per item No **deductible** applies	50% (of the **recognized charge**) per item
Important note: See the *Breast feeding durable medical equipment* section of the booklet-certificate for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Counseling services		
Contraceptive counseling services maximum visits per 12 months, in either a group or individual setting	2 visits*	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under *Physicians and other health professionals*.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Devices		
Female contraceptive device provided, administered, or removed, by a **health professional** during an office visit	100% (of the **negotiated charge**) per item No **deductible** applies	50% (of the **recognized charge**) per item
Female voluntary sterilization		
Inpatient and other services and supplies	100% (of the **negotiated charge**) per admission No **deductible** applies	Covered according to the type of benefit and the place where the service is received
Outpatient	100% (of the **negotiated charge**) per visit No **deductible** applies	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
2. Physicians and other health professionals		
Physician services		
Office hours visit (non-surgical), non-preventive care, in a **physician's** office	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Telemedicine consultation by a **physician**	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not applicable
Important note: Telemedicine services received through Teladoc® have a $0 **copayment**. Learn more at teladoc.com/aetna.		
Specialist services		
Office hours visit (non-surgical), in a **specialist's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Telemedicine consultation by a **specialist**	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not applicable
Important note: Telemedicine services received through Teladoc® have a $0 **copayment**. Learn more at teladoc.com/aetna.		
Other health professional services		
Office hours visit (non-surgical), in a **health professional's** office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections		
Performed at a **health professional's** office, when you see the **health professional**	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Performed at a **specialist's** office, when you see the **specialist**	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Performed without an associated office visit to your **health professional**	70% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit No **deductible** applies
Allergy testing and treatment		
Performed at a **health professional's** office	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Performed at a **specialist's** office	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Immunizations that are not considered preventive care		
Immunizations that are not considered preventive care	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Physician surgical services		
Performed at a **physician's** office	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Performed at a **specialist's** office	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Alternatives to physician and other health professional office visits		
Walk-in clinic visits		
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Individual screening and counseling services at a walk-in clinic		
Obesity and/or healthy diet screening and counseling services		
Individual screening and counseling services for obesity and/or healthy diet	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Maximum benefit - Individual screening and counseling services	Refer to the *Preventive care and wellness* section earlier in this schedule of benefits for maximums that may apply to these types of services	Not covered
Tobacco screening and counseling services		
Individual screening and counseling services for use of tobacco products	100% (of the **negotiated charge**) per visit No **deductible** applies	Not covered
Maximum benefit - Individual screening and counseling services	Refer to the *Preventive care and wellness* section earlier in this schedule of benefits for maximums that may apply to these types of services	Not covered
All other non-preventive care services for which cost sharing is not shown above		
All other non-preventive care other services	• 70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
3. Hospital and other facility care		
Hospital care		
Inpatient **hospital** (**room and board**) and other services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Alternatives to hospital stays		
Outpatient surgery and physician surgical services		
Performed in the outpatient department of a **hospital**	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Performed in a facility other than a **hospital** outpatient department	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Performed at a **physician's** office	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Home health care		
Outpatient	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per 12 months	200 Combined for *Home health care* and *Outpatient private duty nursing*	200 Combined for *Home health care* and *Outpatient private duty nursing*
Hospice care		
Inpatient facility (**room and board**) and other services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Outpatient	• 70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Outpatient private duty nursing		
Outpatient private duty nursing	• 70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Maximum visits per 12 months	200 Combined for *Home health care* and *Outpatient private duty nursing*	200 Combined for *Home health care* and *Outpatient private duty nursing*

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Skilled nursing facility		
Inpatient facility (**room and board**) and other services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Maximum days per 12 months	30	30

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
4. Emergency services and urgent care		
Emergency services		
Hospital emergency room	$250 then the plan pays 70% (of the balance of the **negotiated charge**) per visit thereafter	$250 then the plan pays 70% (of the balance of the **recognized charge**) per visit thereafter
Non-emergency care in a **hospital** emergency room	$250 then the plan pays 70% (of the balance of the **negotiated charge**) per visit thereafter	$250 then the plan pays 70% (of the balance of the **recognized charge**) per visit thereafter
Important note: • As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share (**deductible, copayment** and **coinsurance**, if any) as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. • A separate **hospital** emergency room **copayment**/**coinsurance** will apply for each visit to an emergency room. If you are admitted to a **hospital** as an inpatient right after a visit to an emergency room, your emergency room **copayment**/**coinsurance** will be waived and your inpatient **copayment**/**coinsurance** will apply.		
Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Non-urgent care from an **urgent care provider**	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
A separate urgent care **copayment**/**coinsurance** will apply for each visit to an **urgent care provider**.		

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
5. Specific conditions		
Autism spectrum disorder		
Autism spectrum disorder (including applied behavioral analysis)	• Covered according to the type of benefit and the place where the service is received	• Covered according to the type of benefit and the place where the service is received
Birthing center		
Inpatient (**room and board**) and other services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Diabetic equipment, supplies and education		
Diabetic equipment, supplies and education	• Covered according to the type of benefit and the place where the service is received	• Covered according to the type of benefit and the place where the service is received
Family planning services - other		
Voluntary sterilization for males		
Inpatient (**room and board**) and other services and supplies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Abortion		
Inpatient (**room and board**) and other services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Outpatient	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Maternity and related newborn care		
Inpatient (**room and board**) and other maternity and related newborn care services and supplies	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
***Important note:** The per admission amount for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility **stay**. The nursery charges waiver will not apply for non-		

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routine facility **stays**.		
Mental health treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Mental health treatment - outpatient		
Outpatient mental health treatment office visits to a **health professional** (includes **telemedicine** consultation)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter • No **deductible** applies	50% (of the **recognized charge**) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Substance related disorders treatment - inpatient		
Inpatient (**room and board**) facility and other inpatient services and supplies, including **residential treatment facilities**	70% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Substance related disorders treatment - outpatient		
Outpatient **substance abuse** office visits to a **health professional** (includes **telemedicine** consultation)	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter • No **deductible** applies	50% (of the **recognized charge**) per visit

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Other outpatient **substance abuse** services (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	100% (of the **negotiated charge**) per visit No **deductible** applies	50% (of the **recognized charge**) per visit
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Oral and maxillofacial treatment (mouth, jaws and teeth)	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage* Network (IOE facility)	In-network coverage* Network (Non-IOE facility)	Out-of-network coverage*
Transplant services facility and non-facility			
Inpatient **hospital** transplant services (**room and board**) and supplies	70% (of the **negotiated charge**) per admission	50% (of the **negotiated charge**) per admission	50% (of the **recognized charge**) per admission
Physician services, including office visits	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Lifetime maximum benefit payable for travel and lodging expenses for any one transplant, including tandem transplants	$10,000	Not applicable - Coverage limited to network IOE only	Not applicable- Coverage limited to network IOE only
Maximum benefit payable for lodging expenses per IOE patient	$50 per night	Not applicable - Coverage limited to network IOE only	Not applicable - Coverage limited to network IOE only
Maximum benefit payable for lodging expenses per companion	$50 per night	Not applicable - Coverage limited to network IOE only	Not applicable - Coverage limited to network IOE only

Eligible health services	In-network coverage*	Out-of-network coverage*
Treatment of infertility		
Basic infertility		
Basic **infertility**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
6. Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services		
Performed in a **hospital** or facility	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Diagnostic lab work		
Performed in a **hospital** or facility	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Diagnostic radiological services		
Performed in a **hospital** or facility	70% (of the **negotiated charge**) per visit	50% (of the **recognized charge**) per visit
Genetic and prenatal testing		
Genetic and prenatal testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy		
Outpatient infusion therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation		
Cardiac rehabilitation	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Pulmonary rehabilitation		
Pulmonary rehabilitation	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Short-term rehabilitation services		
Short-term rehabilitation services	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per 12 months *Autism Spectrum Disorders are not subject to this maximum*	30 Combined for outpatient massage, physical, occupational and speech rehabilitation therapies	30 Combined for outpatient massage, physical, occupational and speech rehabilitation therapies
Habilitation therapy services		
Outpatient physical, occupational, and speech therapies	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per 12 months *Autism Spectrum Disorders are not subject to this maximum*	Unlimited	Unlimited

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Neurodevelopmental therapy		
Neurodevelopmental therapy	$50 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per 12 months	Unlimited	Unlimited

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
7. Other services		
Acupuncture		
Acupuncture	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per 12 months *This does not apply to treatment due to substance abuse*	12	12
Ambulance service		
Emergency use of ambulance (air, ground and water)	70% (of the **negotiated charge**) per trip	Same as in-network
Clinical trials (routine patient costs)		
Clinical trial routine patient costs	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)		
Durable medical equipment	70% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Experimental or investigational therapies		
Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Nutritional supplements		
Nutritional supplements, phenylketonuria treatment, and any other special medical formulas	70% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Orthotic devices		
Orthotic devices	70% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item
Prosthetic devices		
Prosthetic devices	70% (of the **negotiated charge**) per item	50% (of the **recognized charge**) per item *Wigs are limited to $500 per 12 months*
Spinal manipulation		
Spinal manipulation	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies	50% (of the **recognized charge**) per visit
Maximum visits per 12 months	12	12
All other services for which cost sharing is not shown above		
All other services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Aetna Life Insurance Company
Rider

Outpatient prescription drugs

Rider effective date: November 1, 2018

Policyholder: Washington Education Association
Group Policy No.: 285730
Effective Date: November 1, 2017

This **prescription drugs** rider is added to your booklet-certificate. This rider is subject to all of the requirements described in your booklet-certificate. This rider describes your outpatient **prescription drugs** benefit, subject to the following requirements.

Your prescription drug rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your **prescription drugs** benefit, please contact us by calling the number on your ID card or visit www.aetna.com. If you would like to know more about your rights, or if you have concerns about your plan, you may contact the Washington Office of the Insurance Commissioner at 800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or **pharmacies** serving you, please contact the Washington Department of Health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

What you need to know about your outpatient prescription drugs plan

Read this section carefully so that you know:

- How to access **network pharmacies**
- How the **drug guide** works
- **Eligible health services** under your plan
- What outpatient **prescription drugs** are covered
- Other services
- How you get an emergency **prescription** filled
- Where your schedule of benefits fits in
- What **precertification** requirements apply
- How to request a medical exception
- What your plan doesn’t cover – some **eligible health service** exclusions
- Glossary

Some **prescription drug**s may not be covered or coverage may be limited. This may happen because:

- A **prescription drug** is not included on the **drug guide**. See the *How the drug guide works* section. The **drug guide** may change at any time. A copy of the **drug guide** is available at your request. Or you can find it on the **Aetna** website at www.aetna.com/formulary.

- A **prescription drug** is a therapeutic alternative to a **prescription drug** on the **drug guide**, but you do not have an approved medical exception. See the *How to request a medical exception* section.
- **Precertification** or **step therapy** is required. See the *What precertification requirements apply* section.

This does not keep you from getting **prescription drug**s that are not **covered benefits**. You can still fill your **prescription**, but you have to pay for it yourself. For more information see the *Where your schedule of benefits fits in* section, and see the schedule of benefits.

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

How to access network pharmacies

You can find a **network pharmacy** in two ways:

- **Online:** By logging onto your **Aetna** secure member website at www.aetna.com.
- **By phone:** Call the number on your ID card. During regular business hours, a representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any **network pharmacy**. If you fill your **prescriptions** at a **network pharmacy**, you may be eligible to get **prescription drugs** at a lower cost share. See the schedule of benefits for details. **Pharmacies** include **network retail**, **mail order** and **specialty pharmacies**.

How the drug guide works

Your outpatient **prescription drugs** plan is based on drugs in the **drug guide.** The **drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs.** Your out-of-pocket costs may be higher if your **prescriber** prescribes a **prescription drug** not listed in the **drug guide**.

The **drug guide** contains **prescription drugs** that have been reviewed by **Aetna**'s Pharmacy and Therapeutics Committee. This Committee:

- Reviews the entire **drug guide** at least annually
- Meets regularly to review new drugs and new information about drugs that already are in the marketplace
- Reviews available information concerning safety, effectiveness, and current use in therapy
- Reviews information from a variety of sources, including peer reviewed journals and databases, and information from medical professional associations, national commissions, and federal government agencies

Using this information, the Committee evaluates the therapeutic effectiveness of new **prescription drugs** and places them into one of six categories:

- **Category 1:** Provides effective therapy for a disease not adequately treated by any marketed drug, or improved effectiveness or safety
- **Category 2:** Therapeutically similar to other available products, and clinical differences are not significant
- **Category 2+:** Therapeutically similar to other available products, but has clinical advantages (clinical efficacy, adverse effects, drug interactions, etc.)

- **Category 2-:** Therapeutically similar to other available products, but has clinical disadvantages (clinical efficacy, adverse effects, drug interactions, etc.)
- **Category 3:** Not appropriate for the **drug guide**, usually because of significant disadvantages
- **Category 4:** May have an important role for certain patient populations, or as a second- or third-line alternative

We will make a decision to include or not include **prescription drugs** on the **drug guide** based on these categories. For **prescription drugs** that are therapeutically similar, we also consider the cost and effectiveness, and any new or changing regulations.

It is important to review the **drug guide** often. The **drug guide** may change at any time. We may add or remove **prescription drugs**. Or a **prescription drug** may move to a different tier, which may affect the amount you have to pay. This may happen because:

- A new **prescription drug** may have received approval
- A **prescription drug** is no longer being prescribed
- A **generic prescription drug** may have become available

If a change in the **drug guide** affects a **prescription drug** you are taking, you or your **prescriber** should contact us. See the *How to request a medical exception* section.

A copy of the **drug guide** or information about the availability of a specific **prescription drug** may be requested by calling **Aetna** at the number on your ID card. Or you can find it on our website at www.aetna.com/formulary.

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

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

Eligible health services under your plan

What does your outpatient prescription drugs plan cover?

Any **pharmacy** service that meets these three requirements:

- They are listed in this section
- They are not carved out in the *What your plan doesn't cover - some eligible health service exclusions* section
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan's general rules:

- You need a **prescription** from your **prescriber.**
- Your drug needs to be **medically necessary** for your **illness** or **injury.** See the *Medical necessity and precertification* requirements section of your booklet-certificate and the *What precertification requirements apply* section below.
- You need to show your ID card to the **pharmacy** when you get a **prescription** filled.

Generic prescription drugs may be substituted by your pharmacist for **brand-name prescription drugs**. Your out-of-pocket costs may be less if you use a **generic prescription drug** when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing **provider** and/or one **network pharmacy**, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What outpatient prescription drugs are covered

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

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

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

Retail pharmacy

Generally, **retail pharmacies** may be used for up to a 30 day supply of **prescription drugs**.

You should show your ID card to the **network pharmacy** every time you get a **prescription** filled. The **network pharmacy** will submit your claim. You will pay any cost sharing directly to the **network pharmacy**.

If you receive medications for chronic condition you may be able to have your refills synchronized. Synchronizing your medications means fewer trips to the **pharmacy** for refills. Contact us for more information and to see if you qualify.

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

Mail order pharmacy

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

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 31 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

Specialty pharmacy

Specialty prescription drugs often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. You can access the list of **specialty prescription drugs** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.

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

All **specialty prescription drugs** fills after the initial fill must be filled at a **network specialty pharmacy** except for urgent situations.

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient **prescription drugs** plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drugs** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card. We cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost share. If a **generic prescription drug or device** is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method at no cost share.

Covered contraceptives can be filled for a 12-month supply, unless:

- You request a smaller supply
- Your **prescriber** decides you need a small supply

You may be able to receive your covered contraceptive at your **provider's** office.

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

Diabetic supplies

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

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

See your medical plan benefits for coverage of blood glucose meters and insulin pumps.

Infertility drugs

Eligible health services include oral **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

Off-label use

U.S. Food and Drug Administration (FDA) approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information)
  - Thomson Micromedex DrugDex System (DrugDex)
  - Clinical Pharmacology (Gold Standard, Inc.) or,
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - The dosage of a drug for your condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above, or
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

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

Orally administered anti-cancer drugs, including chemotherapy drugs

Eligible health services include any drug prescribed for the treatment of cancer if it is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Over-the-counter drugs

Eligible health services include certain over-the-counter medications. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto your **Aetna** secure member website at www.aetna.com.

Preventive care drugs and supplements

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

Risk reducing breast cancer prescription drugs

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

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

Tobacco cessation prescription and over-the-counter drugs

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

How you get an emergency prescription filled

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

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

Where your schedule of benefits fits in

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

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

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

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

How your copayment/coinsurance works

Your **copayment/coinsurance** is the amount you pay for each **prescription** fill or refill, in addition to your **deductible**, if any. Your schedule of benefits shows you which **copayments/coinsurance** you need to pay for specific **prescription** fill or refill. You will pay any cost sharing directly to the **network pharmacy**.

How your outpatient prescription drug deductible works

Your outpatient **prescription drug deductible** is the amount you need to pay for outpatient **prescription drug eligible health services** before your plan begins to pay some or all of the expenses for outpatient **prescription drug eligible health services**.

Your schedule of benefits shows the outpatient **prescription drug deductible** amounts that apply to your plan. Once you have met your outpatient **prescription drug deductible**, we will start sharing the cost when you get outpatient **prescription drug eligible health services**. You will continue to pay **copayments** for **covered benefits** after you satisfy any applicable **deductible**.

What precertification requirements apply

For certain drugs, you, your **prescriber** or your pharmacist needs to get approval from us before we will cover the drug. This is called "**precertification**". The requirement for getting approval in advance guides appropriate use of **precertified** drugs and makes sure they are **medically necessary**. For the most up-to-date information, call the number on your ID card or log on to your **Aetna** secure member website at www.aetna.com.

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You will find the **step therapy prescription drugs** on the **drug guide .** For the most up-to-date information, call the number on your ID card or log on to your **Aetna** secure member website at www.aetna.com.

How to request a medical exception

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not listed on the **drug guide** or for **brand-name** and **specialty prescription drugs**, or for which health care services are denied through **precertification** and **step therapy.** You, someone who represents you, or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision and will not apply to other members. If approved by us, you will receive the network benefit level.

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

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

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

Prescribing units

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

Some outpatient **prescription drugs** are limited to 100 units dispensed per **prescription** order or refill. Drugs that are allowed to be filled with a greater than 30 day supply are limited to 300 units dispensed per **prescription** order or refill.

Any outpatient **prescription drug** that has duration of action extending beyond 1 month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for 3 months would require 3 **copayments**.

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

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods except as specifically provided in the *Eligible health services under your plan – Nutritional supplements* section of your booklet-certificate

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed

- Which do not, by federal or state law, require a **prescription** order i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**, including **biosimilars** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- 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
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

Immunizations related to travel or work

Immunization or immunological agents, except as specifically provided in the *Eligible health services under your plan* section

Implantable drugs and associated devices except as specifically provided in the *Eligible health services under your plan* section

Infertility

- **Injectable prescription drugs** used primarily for the treatment of **infertility**

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.
- Needles and syringes, except for those used for self-administration of an injectable drug.
- Any drug, which due to its characteristics must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section of your booklet-certificate

Prescription drugs:

- Dispensed by other than a **retail**, **mail order** or **specialty pharmacy**, except as specifically provided in the *What prescription drugs are covered* section.
- Dispensed by a **mail order pharmacy** that is an **out-of-network pharmacy**, except in a medical emergency or urgent care situation except as specifically provided in the *How to get an emergency prescription filled* section.
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.
- That are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **drug guide** or the product on the **drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Refills

- Refills dispensed more than one year from the date the latest **prescription** order was written

Replacement of lost or stolen prescriptions

Smoking Cessation

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

Test agents except diabetic test agents

We reserve the right to exclude:

A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **drug guide**

Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **drug guide**

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this rider. Please refer to your booklet-certificate for additional definitions for those **bold type** words and phrases that are not listed.

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand-name by the company that manufactures it, usually by the company which develops and patents it.

Drug guide

A list of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list can be reviewed and changed by **Aetna** or an affiliate. A copy of the **drug guide** is available at your request. Or you can find it on the **Aetna** website at www.aetna.com.

Generic prescription drug

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

Mail order pharmacy

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

Negotiated charge

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

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

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

Network pharmacy

A **retail pharmacy**, **mail order pharmacy** or **specialty pharmacy** that ius listed as an Aetna National Network **network pharmacy**, and has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Non-preferred drug

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

Out-of-network pharmacy

A **pharmacy** that is not a **network pharmacy**.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

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

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

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

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

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

Specialty prescription drugs
These are **prescription drugs** that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these **specialty prescription drugs** by calling the number on your ID card or by logging on to your **Aetna** secure member website at www.aetna.com. The list also includes biosimilar **prescription drugs**.

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

Step therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of **step therapy** drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on our website at www.aetna.com.

Therapeutic drug class
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**.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/coinsurance**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with any **deductibles** and **copayments/coinsurance** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
- "In-network coverage", we mean you get care from **network providers**
  - "Out-of-network coverage", we mean you can get care from **out-of-network providers**
- The **deductibles** and **copayments/coinsurance** listed in the schedule of benefits below reflect your **deductibles** and **copayment/coinsurance** amounts.
- You are responsible to pay any **deductibles** and **copayments/coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- This plan has maximums for specific **covered benefits**. For example, these could be supply limit maximums.
- At the beginning of this schedule you will find detailed explanations about your:
  - **Prescription drug deductible**
  - **Copayments/coinsurance**

Important note: All **covered benefits** are subject to any **deductible** and **copayment/coinsurance** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact us by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.

General coverage provisions

This section provides detailed explanations about the:
- Outpatient **prescription drug deductible**
- **Copayments/coinsurance**

Copayments

The specific dollar amount you have to pay for a **prescription drug** listed in the schedule of benefits below.

Coinsurance

The specific percentage you and the plan have to pay for a **prescription drug** listed in the schedule of benefits below.

Outpatient prescription drug deductible provisions

The **plan year** outpatient **prescription drug deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/coinsurance** for **eligible health services** to which the outpatient **prescription drug deductible** does not apply.

Individual

This is the amount you owe for **eligible health services** each **plan year** before the plan begins to pay for **eligible health services**. This **plan year** outpatient **prescription drug deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the **plan year** outpatient **prescription drug deductible**, this plan will begin to pay for **eligible health services** for the rest of the **plan year**.

Family

This is the amount you and your covered dependents owe for **eligible health services** each **plan year** before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family **plan year** outpatient **prescription drug deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the **plan year.**

To satisfy this family **deductible** limit for the rest of the **plan year**, the combined **eligible health services** that you and each of your covered dependents incur towards the individual **plan year** outpatient **prescription drug deductibles** must reach this family outpatient **prescription drug deductible** limit in a **plan year**.

When this occurs in a **plan year**, the individual **plan year** outpatient **prescription drug deductibles** for you and your covered dependents will be considered to be met for the rest of the **plan year**.

Plan features		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Outpatient prescription drug deductible		
A separate **deductible** applies to **prescription drugs.** You have to meet your **deductible** before this plan pays for benefits.		
Individual	$750 per **plan year**	Not applicable
Family	$1,500 per **plan year**	Not applicable
Deductible and copayment/coinsurance waiver for risk reducing breast cancer prescription drugs		
The **deductible**, if any, and the per **prescription copayment**/**coinsurance** will not apply to risk reducing breast cancer **prescription drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **prescription drugs** will be paid at 100%.		
Deductible and copayment/coinsurance waiver for contraceptives		
The **deductible**, if any, and the per **prescription copayment**/**coinsurance** will not apply to female contraceptive when obtained at a **network pharmacy**. This means that the following will be paid at 100%: • Certain over-the-counter (OTC) and generic contraceptive **prescription drugs** and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drug** for that method paid at 100%. The **deductible**, if any,and the per **prescription copayment**/**coinsurance** continue to apply to **prescription drugs** that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.		
Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The **deductible**, if any, and the per **prescription copayment**/**coinsurance** will not apply to two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **retail network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **deductible**, if any, and any **prescription copayment**/**coinsurance** will apply after those two regimens have been exhausted.		

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Tier 1 - Preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is $15 per supply, then the plan pays 100%	Not covered
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is $30 per supply, then the plan pays 100%	Not covered
Tier 2 - Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is $30 per supply, then the plan pays 100%	Not covered
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is $60 per supply, then the plan pays 100%	Not covered
Tier 3 - Non-preferred generic and brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	**Copayment** is $50 per supply, then the plan pays 100%	Not covered
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	**Copayment** is $100 per supply, then the plan pays 100%	Not covered
Tier 4 - Specialty prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **specialty pharmacy** or **retail pharmacy**	**Coinsurance** is 70% (of the **negotiated charge**) per supply	Not covered

Diabetic drugs, supplies and insulin		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug per the *schedule of benefits* above*	Not covered
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the *schedule of benefits* above*	Not covered
*Syringes and needles received from a network **retail pharmacy** or network **mail order pharmacy** have a $0 **copayment.**		
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a **retail pharmacy**	100% per **prescription** or refill	Not covered
More than a 30 day supply but less than a 91 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the *schedule of benefits* above	Not covered
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 30 day supply	100% per **prescription** or refill	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits above. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not applicable

Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a **pharmacy** for each 30 day supply	100% per **prescription** or refill	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not applicable
Important note: See *Outpatient prescription drugs, contraceptive drugs and devices, Preventive care drugs and supplements, Risk reducing breast cancer prescription drugs and Tobacco cessation prescription and over-the-counter drugs* section for more information on other **prescription drug** coverage under this plan.		
Vaccines and immunizations obtained at the pharmacy		
Certain vaccines and immunizations can be obtained from the **pharmacy**	100% per vaccine or immunization	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not applicable

Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy** for each 30 day supply	100% per **prescription** or refill	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact **Aetna** by logging onto your **Aetna** secure member website at www.aetna.com or calling the number on your ID card.	Not applicable
Important note: See *Outpatient prescription drugs, contraceptive drugs and devices, Preventive care drugs and supplements, Risk reducing breast cancer prescription drugs and Tobacco cessation prescription and over-the-counter drugs* section for more information on other **prescription drug** coverage under this plan.		

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)

Washington Education Association

Your Group Life and Accidental Death and Dismemberment Plan

Policy 603254 011
Group 001 (Life with Medical – Active Employees)

Underwritten by Unum Life Insurance Company of America

11/01/2017

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in easy to understand terms. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to WEA), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at WEA's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

WEA'S ORIGINAL PLAN EFFECTIVE DATE: November 1, 2013

IDENTIFICATION NUMBER: 603254 011

ELIGIBLE GROUP(S):

All eligible employees, in active employment in the United States with an Employer, who are a covered subscriber on the WEA Select Medical Plan, through Aetna.

WAITING PERIOD:

For employees in an eligible group on or before November 1, 2017: First of the month coincident with or next following date of active employment

For employees entering an eligible group after November 1, 2017: First of the month coincident with or next following date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$12,500

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

On the first day of the month following the date you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65 ($8,125); or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70 ($8,125).

There will be no further increases in your amount of life insurance.

On the first day of the month following the date you have reached age 70 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction (6,250); or
- 50% of the amount of life insurance shown above if you become insured on or after age 70 ($6,250).

There will be no further increases in your amount of life insurance.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

Premium Waiver

The above items are only highlights of this plan. For a full description of your coverage, please refer to the full certificate of coverage on Aetna's web site: www.weaselect.aetna.com, or you may request a copy by calling Aon at (206) 467-4646.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

WEA'S ORIGINAL PLAN EFFECTIVE DATE: November 1, 2013

IDENTIFICATION NUMBER: 603254 011

ELIGIBLE GROUP(S):

All eligible employees, in active employment in the United States with an Employer, who are a covered subscriber on the WEA Select Medical Plan, through Aetna.

WAITING PERIOD:

For employees in an eligible group on or before November 1, 2017: First of the month coincident with or next following date of active employment

For employees entering an eligible group after November 1, 2017: First of the month coincident with or next following date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

$12,500

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

On the first day of the month following the date you have reached age 65, but not age 70, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 65 ($8,125); or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 65 but before age 70 ($8,125).

There will be no further increases in your amount of AD&D insurance.

On the first day of the month following the date you have reached age 70 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction ($6,250); or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70 ($6,250).

There will be no further increases in your amount of AD&D insurance.

Covered Losses	Benefit Amounts
Life	The Full Amount
Both Hands or Both Feet or Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
Speech and Hearing	The Full Amount
Hemiplegia	The Full Amount
Paraplegia	The Full Amount
Quadriplegia	The Full Amount
Triplegia	Three Quarters The Full Amount
One Hand or One Foot	One Half The Full Amount
Sight of One Eye	One Half The Full Amount
Speech or Hearing	One Half The Full Amount
Thumb and Index Finger of Same Hand	One Quarter The Full Amount
Uniplegia	One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount: Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $10,000.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $5,000.

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments: 4 per lifetime

Maximum Benefit Amount: $24,000

Maximum Benefit Period: 6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

FELONIOUS ASSAULT BENEFIT FOR YOU

Benefit Amount: 50% of the Full Amount of your accidental death and dismemberment insurance benefit, to a maximum of $6,250.

The Felonious Assault Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order to receive the Felonious Assault Benefit, your accidental death and dismemberment must be paid first.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

The above items are only highlights of this plan. For a full description of your coverage, please refer to the full certificate of coverage on Aetna's web site: www.weaselect.aetna.com**, or you may request a copy by calling Aon at (206) 467-4646.**