# Open Access Aetna Select medical plan

## Booklet

**Prepared for:**

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**Third Party Administrative Services provided by**
**Aetna Life Insurance Company**

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# Welcome

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

Welcome to Aetna.

## Introduction

This is your booklet. It describes your **covered services** – what they are and how to get them. It also describes how we manage the plan, according to our policies, and applicable laws and regulations. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Together, these documents describe the benefits covered by your Employer's self-funded health benefit. Each may have amendments attached to them. These change or add to the document. This booklet takes the place of any others sent to you before.

It's really important that you read the entire booklet and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits - Effect of prior plan coverage* section.

If you need help or more information, see the *Contact us* section below.

## How we use words

When we use:

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

## Contact us

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

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

- Calling the toll-free number on your ID card
- Writing us at 151 Farmington Ave, Hartford, CT, 06156
- Visiting https://aetnastateflorida.com to access additional details about the plan

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

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

## Your ID card

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

## Discount arrangements

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

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but, we have the right to change or end the arrangements at any time.

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

# Coverage and exclusions

## Providing covered services

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

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

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

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

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

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

## Acupuncture

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

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

## Ambulance services

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

### Emergency

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

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

### Non-emergency

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

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

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

## Applied behavior analysis

**Covered services** include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

## 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.

**Covered services** include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

## Behavioral health

### Mental health treatment

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

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

### Substance related disorders treatment

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

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

- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your **physician** orders them
  - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

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

## Clinical trials

### Routine patient costs

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

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

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

**Covered services** include:

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

## Durable medical equipment (DME)

**Covered services** are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home

- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

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

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

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

The following are not **covered services**:
- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

## Emergency services

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

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

Your coverage for **emergency services** will continue until the following conditions are met:
- You are evaluated and your condition is stabilized and
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

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

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

## Foot orthotic devices

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

- Shall not include shoe buildups, shoe orthotics, shoe braces or shoe supports unless the shoe is attached to a brace unless Medically Necessary for the treatment of diabetes.

## Habilitation therapy services

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

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

### Outpatient physical, occupational, and speech therapies

**Covered services** include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development

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

The following are not **covered services**:

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

## Hearing exams

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

- Cochlear implants include internal and external components like:
    - Audio input selectors
    - Microphone headsets
    - Speech processors

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Hearing tests to determine if a hearing aid is needed are not covered.

## Home health care

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

- You are homebound
- Your **physician** orders them

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

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

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

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

The following are not **covered services**:
- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation

## Hospice care

**Covered services** include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:
- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological and dietary counseling
- Pain management and symptom control including massage therapies

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

The following are not **covered services**:
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will

- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

## Hospital care

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

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

The following are not **covered services**:

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

## Infertility services

### Basic infertility

**Covered services** include seeing a **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**.

The following are not **covered services**:

- All **infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Intrauterine (IUI) /intracervical (ICI) insemination services.

## Jaw joint disorder treatment

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

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

The following are not **covered services**:

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

## Maternity and related newborn care

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

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery

- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier
- Services and supplies related to births that take place in the home performed by licensed midwives

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any facility charges included with births that take place in the home

## Nutritional support

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

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

The following are not **covered services**:

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

## Obesity surgery and services

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

**Covered services** include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription** drugs included under the *Prescription drugs – outpatient* section
- An obesity surgical procedure, unless determined by the plan to be medically necessary
- A multi-stage procedure when planned and approved by the plan
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the booklet.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - 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

## Oral and maxillofacial treatment (mouth, jaws and teeth)

**Covered services** include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out:
  - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth.
  - Only when not associated with the removal, replacement or repair of teeth

## Outpatient surgery

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

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

The following are not **covered services**:

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

## Physician services

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

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

**Important note:**
For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead.

**Telemedicine** may have a different cost share from other **physician** services. See your schedule of benefits.

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

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

## Preventive care

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

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

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

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

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

### Breast-feeding support and counseling services

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

### Breast pump, accessories and supplies

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

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

### Counseling services

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

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

### Family planning services – contraceptives

**Covered services** include family planning services as follows:

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

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

- 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

### Immunizations

**Covered services** include preventive immunizations for infectious diseases. When required for travel, or when needed for school, employment, insurance or governmental licensing, except insofar as such immunizations and examinations are within the scope of, and coincide with, the periodic health assessment examination and/or state law requirements and/or the preventive care requirements of the Patient Protection and Affordable Care Act.

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

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

### Prenatal care

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

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

### Routine cancer screenings

**Covered services** include the following routine cancer screenings:

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

- Sigmoidoscopies

### Routine physical exams

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

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

**Covered services** include:

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

### Well woman preventive visits

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

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

## Private duty nursing - outpatient

**Covered services** include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

## Prosthetic device

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

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

Coverage includes:

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

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

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

## Reconstructive breast surgery and supplies

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

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

## Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects 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
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

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

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

These dental related services are limited to:

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

## Pulmonary rehabilitation services

### Pulmonary rehabilitation

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

## Short-term rehabilitation services

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

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

**Covered services** include:

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

### Cognitive rehabilitation, physical, occupational, and speech therapy

**Covered services** include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

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

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language

- Vocational rehabilitation or employment counseling

## Skilled nursing facility

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

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

## Specialty prescription drugs

**Covered services** include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home

## Telemedicine

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

**Covered services** for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at https://aetnastateflorida.com to review our **telemedicine provider** listing and contact us to get more information about your options.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

## Tests, images and labs - outpatient

### Diagnostic complex imaging services

**Covered services** include:

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

Complex imaging for preoperative testing is covered under this benefit.

### Diagnostic lab work

**Covered services** include:

- Lab
- Pathology
- Other tests

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

### Diagnostic x-ray and other radiological services

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

## Therapies – chemotherapy, GCIT, infusion, radiation

### Chemotherapy

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

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

**Covered services** include GCIT provided by a **physician**, **hospital** or other **provider**.

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- Human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)

- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

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

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

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

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

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *How your plan works – Medical necessity and precertification requirements* section.

**Key Terms**
To help you understand this section, here are some key terms we use.

**Cellular**
Relating to or consisting of living cells.

**GCIT**
Any Services that are:
- Gene-based
- Cellular and innovative therapeutics

We call these "GCIT services".

They have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs.

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

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

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

## Infusion therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

**Covered services** include infusion therapy you receive in an outpatient setting including but not limited to:
- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

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

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

## Radiation therapy
**Covered services** include the following radiology services provided by a **health professional**:
- Accelerated particles
- Gamma ray
- Mesons
- Neutrons
- Radioactive isotopes
- Radiological services
- Radium

## Transplant services

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

This includes the following transplant types:

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

### Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

You must get transplant services from the IOE facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this booklet and schedule of benefits.

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

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

The following are not **covered services**:

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

## Urgent care services

**Covered services** include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

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

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

you are temporarily absent from the service area and getting the health care service cannot be delayed until you return to the service area.

The following are not **covered services**:

- Urgent care obtained from a facility that is out-of-network
- Non-urgent care in an urgent care center

## Virtual primary care (VPC)

VPC provides coverage for eligible in-network **covered services** for persons 18 years of age or older. **Covered services** include basic medical and preventive health care services when provided by a Virtual Primary Care (VPC) **telemedicine provider.**

A VPC **telemedicine provider** is a **provider** who is contracted with us to provide you with VPC **covered services** by **telemedicine.** This **provider** can also be your **PCP**.

**Covered services** include:

- Preventive care
  - Preventive care screening and counseling
  - Preventive care biometric review and analysis:
    - If you will perform self-assessments, when you schedule your first VPC consultation, you'll get tools to do so at no cost to you
    - Your results will be reviewed with your VPC **telemedicine provider**
- Basic medical services
  - General primary care consultations
  - Consultations for non-emergency illness or injury, including **prescriptions**, when needed
  - **Prescription** drug coordination to encourage safe and appropriate use of medications
  - Follow-up care and coordination with **network providers**

Your VPC **telemedicine provider** can help you access **network providers** and **specialists** for **covered services** ordered during your virtual consultation, including:

- Diagnostic lab tests
- Preventive care immunizations
- In-person preventive care
- In-person biometric screenings such as cholesterol and blood sugar testing

Your regular cost share will apply for services not provided by a VPC **telemedicine provider** and for any **prescription** drugs you may need. See the schedule of benefits.

The following are not **covered services**:

- VPC **telemedicine** consultations received from a **provider** who is not a VPC **telemedicine provider**.

## Vision services

**Covered services** include:

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

The following are not **covered services**:

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

purposes

- Radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or astigmatic error; and
- Training or orthoptics, including eye exercises

## Walk-in clinic

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

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

# General plan exclusions

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

## Abortion

Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger and which is elective, performed at any time during a pregnancy.

## Abortion drugs

Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

## Acupuncture

- Acupuncture
- Acupressure

## Biofeedback Services

- And other forms of self-care or self-help training and any related diagnostic testing, hypnosis, meditation, mind expansion, elective psychotherapy such as Gestalt therapy, transactional analysis, transcendental meditation, Ztherapy, and Erhard seminar training (EST).

## Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except as described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section

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

Examples of these are:

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

## Cosmetic services and plastic surgery

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

## Court-ordered services and supplies

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

## Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you
- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance related disorder** treatment):
    - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
    - Services given mainly to:
        - Maintain, not improve, a level of function
        - Provide a place free from conditions that could make your physical or mental state worse

## Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants

## Educational services

Examples of these are:

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

## Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy coverage or to get or keep a license.

- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

## Experimental or investigational

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

## Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

## Gender Affirming Treatment

- Any treatment, drug, or service related to changing sex or sexual characteristics. Examples of these are:
  - **Surgical procedures** to alter the appearance or function of the body
  - Hormones and hormone therapy

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

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

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

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

## Growth/height care

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

## Hearing aids

Any tests, appliances and devices to:

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

## Jaw joint disorder treatment

Surgical and non-surgical medical, dental, diagnostic or therapeutic services related to **jaw joint disorder**

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

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

## Missed appointments
Any cost resulting from a canceled or missed appointment

## Nutritional support
Any food item, including:
- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

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

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

## Personal care, comfort or convenience items
Any service or supply primarily for your convenience and personal comfort or that of a third party. Including but not limited to beauty and barber services, radio and television, guest meals and accommodations, telephone charges, take-home supplies, massages, travel expenses other than Medically Necessary ambulance services that are specifically provided for in the covered benefits section, motel/hotel or other housing accommodations (even if recommended or approved by a physician), air conditioners, humidifiers, dehumidifiers, air purifiers or filters, or physical fitness equipment. Also excluded are services not directly used to render treatment

## Prescription or non-prescription drugs and medicines – outpatient
- Outpatient **prescription** or non-**prescription** drugs and medicines
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

## Routine exams and preventive services and supplies

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

## Services provided by a family member

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

## Services, supplies and drugs received outside of the United States

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

## Sexual dysfunction and enhancement

Any treatment, **prescription** drug, 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 of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

## Strength and performance

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

## Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy unless provided in a hospice or in-home care setting
- Sensory or hearing and sound integration therapy

## Tobacco cessation

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

- Counseling, except as specifically provided in the *Coverage and exclusions* section
- Hypnosis and other therapies
- Nicotine patches
- Gum

## Treatment in a federal, state, or governmental entity

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

## Voluntary sterilization

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

## Wilderness treatment programs

See *Educational services* in this section

## Work related illness or injuries

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

To the extent the Health Plan Member is covered or required to be covered by a workers' compensation law. If the Health Plan Member enters a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, this Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. In addition, if the Health Plan Member is covered by a workers' compensation program that limits benefits if other than specified health care providers are used and the Health Plan Member receives care or services from a health care provider not specified by the program, this Plan shall not cover the balance of any costs remaining after the program has paid.

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

# How your plan works

## How your medical 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. The plan usually pays only when you use a **network provider.**

### Providers

Our **provider network** is there to give you the care you need. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also contact us to ask for a copy of the directory. We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the network. See the Contact us section for more information.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**.

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

### Service area

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

## Who provides the care

### Network providers

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

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

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

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

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

### Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

#### How you choose your PCP

You can choose a **PCP** from the list of **PCP**s in our directory. Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

#### What your PCP will do for you

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

#### Changing your PCP

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

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

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

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

However, in some cases, you may be able to keep going to your current **provider** or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the **provider** or facility ceasing to be in our network. This is called continuity of care. If we know you are under an active treatment plan, we will notify you of the **provider's** or facility's contract termination and how you can submit a request to keep going to your current **provider** or facility. Contact us for additional information.

## Medical necessity and precertification requirements

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

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**

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

## Medically necessary, medical necessity

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

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

## Precertification

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

**In-network**

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

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

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

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

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

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

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

**Types of services that require precertification**

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

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

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

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.

## What the plan pays and what you pay

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

### The general rule

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

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

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

### Negotiated charge

*For health coverage:*

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

For surprise bills, calculations will be made based on the median contracted rate.

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

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

Some of these arrangements are called:

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

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

### Surprise bill

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

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

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

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

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

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:
- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

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

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

The median contracted rate is subject to additional adjustments as specified in federal regulations.

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

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

You may request external review if you want to know if the federal surprise bill law applies to your situation.

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

### Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-**network** coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider precertifies** the service when required

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

You pay the entire expense when:

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

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

### Where your schedule of benefits fits in

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

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

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

## Coordination of benefits

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

### Key Terms

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

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

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

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

### How COB works

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

### Determining who pays

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

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

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

### How COB works with Medicare

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

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If

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

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

## Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same employer.

### Other health coverage updates – contact information

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

### Our rights

We have the right to:

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

## Benefit payments and claims

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

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

### Claim type and timeframes

#### Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours.

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. We will make a decision within 15 days.

#### Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

**Concurrent care claim extension**
A concurrent care claim extension occurs when you need 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**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

**Concurrent care claim reduction or termination**
A concurrent care claim reduction or termination occur 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 if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **payment percentage** 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.

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

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

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

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

## Disclaimer of Liability

Neither Aetna nor the Plan Administrator directly employs any practicing physicians nor any Hospital personnel or physicians. These health care providers are independent contractors and are not the agents or employees of Aetna. Aetna shall be deemed not to be a health care provider with respect to any services performed or rendered by any such independent contractors. Participating Providers maintain the physician/patient relationship with Health Plan Members and are solely responsible for the recommendation and selection of all Medical Services which Participating Providers render to their patients who are Health Plan Members. Aetna has no authority or ability to influence the decisions of healthcare providers in determining the care their patients require. Therefore, neither Aetna nor the Plan Administrator shall be liable for any negligent act or omission committed by any independent practicing physicians, nurses or medical personnel, nor any Hospital or health care facility, their personnel, other health care professionals or any of their employees or agents who may, from time to time, provide Medical Services to a Health Plan Member.

Furthermore, neither Aetna nor the Plan Administrator shall be vicariously liable for any negligent act or omission of any of these independent health care professionals who treat a Health Plan Member of the Plan. Certain Health Plan Members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Physicians. Participating Physicians may regard such refusal to accept their recommendations as incompatible with the continuance of the physician/patient relationship and as obstructing the provision of proper medical care. If a Health Plan Member refuses to accept the medical treatment or procedure recommended by the Participating Physician and if, in the judgment of the Participating Physician, no professionally acceptable alternative exists or if an alternative treatment does exist but is not recommended by the Participating Physician, the Health Plan Member shall be so advised. If the Health Plan Member continues to refuse the recommended treatment or procedure, the State of Florida may terminate the Health Plan Member's coverage under this Plan.

# Complaints, claim decisions and appeals procedures

## The difference between a complaint and an appeal

### A Complaint

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

### An Appeal

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

## Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an "adverse benefit determination" or "adverse decision." For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don't agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an external review.

## 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 Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name
- The 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 by contacting us. You can use an authorized representative at any level of appeal.

**Level I Appeal**

**NOTICE OF WAIVER**

You or your authorized representative may appeal any totally or partially denied medical or prescription drug Claim or any Adverse Benefit Determination. You will WAIVE ALL RIGHTS OF APPEAL, whether it is a Level I or a Level II appeal, if you fail to file your appeal within the time frame indicated on the notice that is mailed to you. Please refer to the applicable information on the appeal process including mandatory appeal filing deadlines in this section.

You or your authorized representative on your behalf have the right to appeal an Adverse Benefit Determination and full or partial denial of benefits or payment of a Claim for Medical Services, supplies, and/or prescription drugs you have received (post-service) or are planning to receive (pre-service). Your appeal must be received by Aetna, as appropriate, within 180 days of the Adverse Benefit Determination notice (the ending statement period date on the Member Health Statement (MHS), the Explanation of Benefits (EOB) Statement, or other notice of denial).

There are three types of appeals: urgent pre-service, pre-service, and post-service. For Aetna, you may request an urgent pre-service appeal if the timeframe to complete a Level I Pre-Service Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal. If your appeal is for the denial of an urgent Pre-Service Claim or a concurrent care decision, you may verbally request an urgent Level I Appeal by calling the customer service toll-free telephone number on your member ID card (Aetna or as appropriate) and stating that you are requesting an urgent Level I Appeal.

If your appeal is for a Pre-Service (non-urgent) or Post-Service Claim, you must submit your Level I Appeal in writing and explain your reason for the appeal. Your appeal may include any additional documentation, information, evidence, or testimony that you would like reviewed and considered during the appeal process.
**Level I Appeal information:**

| **Type of Appeal** | **Contact Information** |
|---|---|
| **Medical appeals through Aetna** | Aetna<br>Attn: National Accounts CRT<br>P.O. Box 153182, Tampa, FL 33684<br><br>(877) 858-6507<br>Fax: (859) 425-3379 |

Prior to the notification of the Level I Appeal decision, you will be provided, free of charge, copies of any new or additional evidence or rationale considered in connection with your Claim and you will be provided an opportunity to respond to such new evidence or rationale.

Aetna, as appropriate, will review your Level I Appeal and provide a written notice of the review decision. If the appeal is for a pre-service denial, Aetna, will respond within 15 days from receipt of your appeal; if the appeal is for a post-service denial, Aetna, will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, Aetna or will respond within 72 hours from receipt of your appeal. If Aetna's review is unfavorable (Level I Appeal is denied), the notice will include information about appealing the decision to DSGI.

**Appealing to Division of State Group Insurance (DSGI)-A Level II Appeal**

If you are not satisfied with the Level I Appeal decision, you may file a Level II Appeal to DSGI. You may request a Level II urgent appeal if the timeframe to complete the pre-service Level II Appeal would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent appeal. If your Level II Appeal is for the denial of a pre-service or concurrent care decision, you may verbally request an urgent Level II Appeal by calling DSGI at 850-921-4600 and stating that you are requesting an urgent Level II Appeal.

If your appeal is for a Pre-Service (non-urgent) or Post-Service Claim, you must submit your Level II Appeal in writing and explain your reason for the appeal. Your appeal may include any additional documentation, information, evidence, or testimony that you would like reviewed and considered during the appeal process.

Your Level II Appeal must be in writing or filed verbally (for urgent appeals) and must be postmarked within 60 days of the written notice of Aetna, denial of your Level I Appeal. Your Level II Appeal must include:

1. A copy of the denial notice (EOB, MHS, or other notice of denial);
2. A copy of your letter to Aetna, requesting a Level I Appeal;
3. A copy of Aetna's Level I Appeal denial;
4. A Level II Appeal letter to DSGI appealing the Level I Appeal decision; and
5. Any other information or documentation that could assist in the review of your appeal.

| | |
|---|---|
| **Level II Appeals:** | Division of State Group Insurance<br>Attention: Appeals Coordinator<br>P.O. Box 5450<br>Tallahassee, FL 32314-5450<br>DSGIAppeals@dms.myflorida.com |

Any Level II Appeal received without, at a minimum, the above information, will be returned to you or the representative who submitted your Level II Appeal. Prior to the notification of the Level II Appeal decision, you will be provided, free of charge, copies of any new or additional evidence or rationale considered in connection with your Claim and you will be provided an opportunity to respond to such new evidence or rationale.

DSGI will review the Level II Appeal and provide a written notice of the review decision. If the Level II Appeal is for a Pre-Service (non-urgent) denial, DSGI will respond within 15 days from receipt of your appeal; if the Level II Appeal is for a post-Service denial, DSGI will respond within 30 days from receipt of your appeal; and, if your appeal is urgent, DSGI will respond within 72 hours from receipt of your appeal. DSGI will notify you within the 72-hour period if your urgent Level II Appeal does not contain sufficient information and/or documentation for a review and decision; the 72-hour period will be suspended when the notice is sent to you. The notice will include a specific due date that DSGI must receive any additional information and/or documentation to review in consideration of your urgent Level II Appeal; the 72-hour period will restart on the noted due date.

If DSGI's review is unfavorable (Level II Appeal is denied), the notice from DSGI will include information of any additional appeal or review rights available to you. Two review options are available if you want to contest the Level II Appeal denial: an administrative hearing and an external review from an independent review organization. You may request a review through either or both options. However, please note that each option has a specific timeframe for requesting a review as described below.

**Requesting** an **Administrative Hearing**
If you want to contest the Level II Appeal decision of DSGI through the State of Florida administrative hearing process, you must submit a petition for an administrative proceeding that complies with Rule 28-106.201 or

28- 106.301, Florida Administrative Code. Your petition must be received within 21 days after you received the written adverse decision on your Level II Appeal.

**Requesting an External Review from an Independent Review Organization(IRO)**
For requests that received a Level I denial from Aetna, and a Level II denial from DSGI, you have the right to request an external review from an independent review organization after the finalization of both the Level I and Level II Appeal processes. You may call the customer service toll-free telephone number on your member ID card (Aetna, as appropriate) for additional information about requesting or to request an external review. External review is not available for Claim denials based on an individual's eligibility under a plan. You may request an external review within four months of receipt of the Level II Appeal decision.

You will find the required forms for filing an External Review request through Aetna to an Independent Review Organization at https://www.mybenefits.myflorida.com/myhealth/forms – "Aetna External/Independent Review Form" and "Aetna Expedited External/Independent Review Form."

**Standard External Review**
You may request a standard external review of your Level II Appeal denial only if:

1. the decision involved a:
    a. denial of your request for payment of a Claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is Experimental or investigational; or
    b. rescission (cancellation) of coverage; and
2. An external review is requested by you within four months of the Level II Appeal denial date.

The IRO will review your request for a standard external review and provide a written notice of the review decision within 45 days from the date of receipt of the request by the IRO.

**Expedited or Urgent External Review**
For requests that received a Level I denial from Aetna, you may request an expedited or urgent external review if the timeframe to complete a standard external review would seriously jeopardize your life or health or your ability to regain maximum function or if in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the urgent external review and only if:

1. The decision involved a:
    a. denial of your request for payment of a Claim and the decision involved a medical judgment including, but not limited to a decision based on medical necessity, appropriateness, healthcare setting, level of care or effectiveness of the health care service or treatment you requested or a determination that the treatment is Experimental or investigational; or
    b. rescission (cancellation) of coverage; and

An external review is requested by you within four months of the Level II Appeal denial date. The IRO will review your request for an urgent external review and provide a response within 72 hours from the date of receipt by the IRO.

**Important Notes:**

1. Throughout the appeal and review process, you have the right to present evidence and testimony as well as request and receive, free of charge, copies of all documents and other information relevant to your Claim and/or appeal, including, but not limited to, the following information about the processing of your Claim:

    - the specific rule, guideline, protocol, or other similar criterion used, if any, in making the benefit or payment decision, and/or

    - an explanation of the scientific or clinical factors relied upon if the Claim was denied in whole or in part based on the lack of medical necessity or the Experimental or investigational nature of a service or medication.

2. A favorable decision by the IRO is binding on the Plan and is cause to interrupt and stop any administrative hearing proceedings. An unfavorable decision by the IRO is binding on the Plan if you did not previously timely pursue action through the administrative hearing process.

3. If, after commencement of any administrative proceeding, you decide to request an external review by the IRO, the administrative proceeding will be held in abeyance pending the IRO decision.

The appeal process described in this Plan Booklet and Benefits Document implements the internal Claims, appeals, and external independent review organization review processes and guidelines as required under the Patient Protection and Affordable Care Act (PPACA), Florida law, and Florida Administrative Code. The appeal process is subject to change if or as required by finalization of current interim federal regulations applicable to the PPACA, change to Florida law, and/or to Florida Administrative Code.

### 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 you fill out an authorized representative form telling us that you are allowing the provider to appeal for you.

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.

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

## Exhaustion of appeals process

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

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

But sometimes you do not have to complete the two levels of 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 and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

## External review

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

You have a right to external review only if:

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

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 123 calendar days (four months) of the date you received the decision from us and you must include a copy of the notice from us and all other important information that supports your request

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

**Aetna** will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision within 45 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 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

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

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

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

## Recordkeeping

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

## Fees and expenses

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

## Bundled Surgical Service and Pricing Transparency Program

The Shared Savings Program is a voluntary program that is available to all Enrollees. Under the Shared Savings Program, Members can earn financial rewards by receiving rewardable healthcare services through Healthcare Bluebook and SurgeryPlus.

Rewards earned by Members will be credited to the Enrollee's State Group Insurance Program health reimbursement account (HRA), post-deductible HRA (for Enrollees in a high deductible health plan), flexible spending account (FSA), limited purpose FSA (for Enrollees in a high deductible health plan), or a health savings account (for Enrollees in a high deductible health plan.) Enrollees may also receive a reimbursement for out-of-pocket healthcare expenses. For any questions about the account(s) that is available to you, please contact Chard Snyder at (855)-824-9284.

**Healthcare Transparency Program**
Healthcare Bluebook is an online transparency website that allows Members to "shop" for healthcare services and providers. Healthcare Bluebook's website (www.healthcarebluebook.com/cc/SOF) and mobile application display the range of costs of covered in-network healthcare services, as well as, a quality ranking developed by Healthcare Bluebook of inpatient facilities.

Healthcare Bluebook allows Members to review the costs of healthcare services based on a Fair Price™ as determined by Healthcare Bluebook. The Fair Price™ is the amount Members should reasonably expect to pay for a service. Healthcare Bluebook's website and mobile application identify the Fair Price™ of a service and categorize the service as follows:

A healthcare service at or below the Fair Price™ is designated with a green symbol; A healthcare service slightly above the Fair Price™ is designated with a yellow symbol; and, A healthcare service with a high price is designated with a red symbol. Some procedures designated with a green symbol are available for rewards. Additional information regarding rewards is provided below.

For some facilities, Healthcare Bluebook will conduct its own quality measures and will display a checkmark to indicate the level of quality. A Green Check-Plus ranking indicates that a hospital is among the top third of all hospitals in the U.S., a Yellow Check indicates that the hospital falls in the middle third of all hospitals, and a Red Check-Minus indicates that the hospital is in the lowest performing third of hospitals in the U.S.

These quality rankings are designed to help Members understand each hospital's level of quality fora particular inpatient clinical area or procedure. Healthcare Bluebook assesses hospital quality for major inpatient clinical categories, such as cardiac surgeries, joint replacement, and neurosurgery.

Individual procedures are then mapped to these clinical categories. The clinical groupings allow Healthcare Bluebook to evaluate how well a hospital performs in different areas of care delivery. For example, patients can use the quality rating to understand how well a hospital performs on heart surgeries when compared to joint surgeries. A hospital may have different quality rankings for different clinical areas (e.g., a hospital may have a green rating for joint replacement and a red rating for cardiac surgeries).

Under the "Go Green to Get Green" rewards program, the Healthcare Bluebook website and mobile application will identify the procedures that have rewards and specify the reward amount. Rewards will be credited to enrollees once all the following occur:

1. The Enrollee or his/her dependent uses Healthcare Bluebook to "shop" for a rewardable healthcare service.
2. The Enrollee or his/her dependent receives the healthcare service from a "green" provider designated by a green • symbol.
3. Healthcare Bluebook validates the Member's receipt of a rewardable healthcare service and that the Member used Healthcare Bluebook to "shop" for the healthcare service; and,
4. Healthcare Bluebook notifies the Division of State Group Insurance that the Enrollee or his/her dependent earned the reward.

**Bundled Surgical Services**

The Bundled Surgical Services, through SurgeryPlus, offers a supplemental benefit that allows Members to reduce their cost for many planned, non-emergency surgical procedures. The SurgeryPlus benefit will assist Members with planning and paying for a covered medical procedure, including necessary travel associated with the covered procedure. SurgeryPlus Care Advocates can educate Members on the quality of providers, identify available providers, schedule appointments, and make necessary travel arrangements. SurgeryPlus's medical procedures are performed by SurgeryPlus's network of healthcare providers. The medical procedures, benefits, and providers offered by SurgeryPlus are separate from the medical benefits offered by the State Employees' HMO Plan (administered by Aetna) as generally described in other sections of this Plan Document. However, the copayments, calendar year deductible, calendar year coinsurance maximum, and global network out-of-pocket maximum amounts set forth in

Section IV may apply and may be reduced; and, the appeal processes set forth in Section VIII will apply to services offered by SurgeryPlus.

**Covered Surgeries and Procedures**
SurgeryPlus offers medical and surgical procedures that are "bundled" together into one Episode of Care[3]. Members will earn one reward for completing an Episode of Care.

SurgeryPlus offers a variety Episodes of Care which may include, but are not limited to, the following:

***Spine***
Fusions
Disk Repair/Replacement
Laminectomy
Laminotomy

***Cardiac***
Cardiac Valve Surgery
Cardiac Defibrillator Implant

***General Surgery***
Gallbladder Removal
Hernia Repair
Thyroidectomy

***Ear, Nose & Throat***
Septoplasty
Sinuplasty
Eustachian Tubes
Thyroidectomy

***Orthopedic***
Knee Replacement
Hip Replacement
Shoulder Replacement
Ankle/Wrist/Elbow Replacement
Arthroscopy
Rotator Cuff Repair
Tendon Repair
Carpal Tunnel Bunionectomy

***Genitourinary***
Hysterectomy
Bladder Repair

***Pain Management***
Cervical Epidural
Lumbar Epidural Steroid
Stellate Ganglion Block

For additional information on available medical procedures, or to determine if your planned surgery is included, please contact SurgeryPlus.

**SurgeryPlus Travel Benefit**
The SurgeryPlus benefit includes travel associated with the Episode of Care. Only travel arrangements made through a SurgeryPlus Care Advocate are eligible for coverage under the SurgeryPlus benefit. The travel benefit depends on the procedure, provider, distance between the provider and the Member's residence, and availability. For procedures requiring inpatient admission or overnight recovery, the travel benefit includes the member and one companion.

[3] "Episode of Care" means (i) all services rendered by a SurgeryPlus network provider and provider's professional and medical staff, as applicable and (ii) all hospital- or facility-related expenses under the diagnosis case code. The Episode of Care begins on the day the patient first receives services from the provider related to the diagnosis case code and ends when the patient is discharged from the hospital or facility to return or travel home. Services and expenses under the diagnosis case code commonly included in the Episode of Care are equipment used while in hospital or facility, in-hospital or in-facility medications or biologics and supplies, implants, labs, in-hospital meals, hospital confinement days, pre- and post in-hospital or in-facility nursing care, in-hospital physical therapy and follow-up consultations, and any other medically necessary care related to the diagnosis case code rendered prior to discharge. An Episode of Care shall not include (i) diagnostic testing in advance to determine whether a procedure is necessary; (ii) personal comfort, hygiene, or convenience items; (iii) procedures or care that are not medically necessary; and (iv) and Serious Reportable Events (SREs) as defined by the National Quality Forum at http://www.qualityforum.org/Home.aspx.

**Process for Using SurgeryPlus**
To receive an Episode of Care through SurgeryPlus, all of the following must occur:

The Member must contact a SurgeryPlus Care Advocate before planning the Episode of Care at (844) 752-6170 or online at Florida.SurgeryPlus.com (Portal Access Code: surgeryplus);

The Member must agree to supply his or her medical records and any other pertinent information to the SurgeryPlus provider so he/she may assess:

- The medical necessity of the procedure; and,
- The Member's suitability for the prospective treatment or procedure, including any necessary travel. This assessment is referred to as the "initial review/consultation";

The Member must be approved for the Episode of Care. The SurgeryPlus provider will determine the medical necessity of the proposed medical procedure based on the initial review/consultation with the member. If a member is not satisfied with the SurgeryPlus provider or the initial review/consultation, the Member may contact a Care Advocate and arrange for a second opinion with another SurgeryPlus provider;

- The Member must accept and agree to the standard terms of treatment of the SurgeryPlus provider.
- Receiving an initial review/consultation does not commit a member to proceed with a procedure from SurgeryPlus; and,
- The Member must verify with SurgeryPlus any out-of-pocket costs associated with the Episode of Care; additionally, the Member must agree to be financially responsible for all out-of-pocket costs associated with the Episode of Care.
- Once the foregoing steps are completed, SurgeryPlus will schedule the Episode of Care.

The SurgeryPlus benefit covers the initial review/consultation, the Episode of Care, and any post-discharge follow- up appointment(s), as prescribed by the SurgeryPlus provider. After completion of the covered care by the SurgeryPlus provider, SurgeryPlus will transfer treatment to the treating provider of the Member's choice.

SurgeryPlus will also provide the Member's medical records to the chosen treating provider to ensure continuity of care. Upon request, SurgeryPlus will also provide the Member's medical records to Aetna.

Coverage for any medical services outside those provided by SurgeryPlus will be determined according to the provisions of this SPD and will be processed by Aetna.

Please note that some of SurgeryPlus's providers may also be in-network providers with Aetna; however, any services you receive through SurgeryPlus will be billed and treated separately from any benefits offered by the State Employees' HMO Plan (administered by Aetna), and the SurgeryPlus benefit will not be processed by Aetna.

**SurgeryPlus Limitations and Exclusions**
Certain examinations, tests, treatments, or other medical services may be required prior to or following the covered services (Episode of Care) with a SurgeryPlus provider. Any medical services performed by anyone other than a SurgeryPlus provider, including pre- and post-care, shall be subject to the covered benefits, exclusions, limitations, and other terms set forth in this SPD.

All claims for Members' SurgeryPlus benefits are considered in-network and will be included toward the calendar year deductible, coinsurance, calendar year coinsurance out-of-pocket maximum, and calendar year global network out-of-pocket maximum of the PPO Plan, as appropriate.

Except for any post-operative follow-up appointments prescribed by the SurgeryPlus provider, any care, emergency or otherwise, following the termination of an Episode of Care is subject to the covered benefits, exclusions, limitations, and other terms set forth in this SPD. The Episode of Care ends when the Member is discharged from the facility.

**The following services are excluded from the SurgeryPlus benefit:**

- Diagnostic studies and imaging, except for plain film x-rays and ultrasounds, prior to admission;
- Physical therapy;
- Durable medical equipment;
- Prescription medications outside the Episode of Care;
- Lab work prior to admission;
- Pre-operative labs and testing (Note: Pre-operative labs and testing must be arranged and billed through your on- going provider and all claims for these services must be submitted to Aetna, not SurgeryPlus, for claim processing); and,
- Complications that occur after termination of an Episode of Care.

**Earning Financial Rewards**

Each Episode of Care offered by SurgeryPlus is eligible for a financial reward. The reward will be designated prior to receipt of the service and will be credited to the Enrollee through a reduction in the Enrollee's out-of-pocket costs and/or as a credit to a State Group Insurance savings and spending account.

How SurgeryPlus works for Enrollees: Enrollees are responsible for paying out-of-pocket costs, as described in Section IV, as applicable, of this SPD. Any applicable out-of-pocket costs may be reduced for Enrollees up to the amount of the financial reward. The remaining portion of the Episode of Care is covered under the SurgeryPlus benefit. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).

Enrollees in a high deductible health plan must meet the deductible amount prior to the SurgeryPlus reward becoming available. Once the Enrollee has met the maximum deductible, the Enrollee's out-of-pocket costs may be reduced, up to the specified reward amount. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).

How SurgeryPlus works for Dependents: Dependents are responsible for paying out-of-pocket costs, as described in Section IV, as applicable, of this SPD. The remaining portion of the Episode of Care is covered under the SurgeryPlus benefit. To the extent that any portion of the reward remains after the payment of any out-of-pocket costs (or when there are no applicable out-of-pocket costs), the remaining portion of the reward will be credited to the Enrollee's savings and spending account(s).

# Eligibility, starting and stopping coverage

## Eligibility

### Who is eligible

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

### When you can join the plan

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

You can enroll:

- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

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

## Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's
  - Dependent children must be:
    - Under 30 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody
    - A grandchild whose parent is already covered as a dependent on this plan

### Adding new dependents

To cover your eligible dependents, you must:

1. Register your dependents online in People First:
2. Select the correct family coverage tier for each plan selected to cover dependents;
3. Enroll each dependent in the appropriate plan, and;
4. Click the *Complete Enrollment* button in People First.
5. Upload required documents.

In accordance with Chapter 60P, Florida Administrative Code, your dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. For purposes of this SPD, the eligible

| | |
|---|---|
| **Enrollee's legal spouse** | • As defined in section 741.212, Florida Statutes |

| | |
|---|---|
| **Enrollee's children from birth through the end of the calendar year in which they turn age 26:** | • Natural children, legally adopted children and children placed in the home for the purpose of adoption in accordance with chapter 63, Florida Statutes<br>• Stepchildren, provided the Enrollee is still married to the children's parent<br>• Foster children<br>• Children for whom the subscriber has established legal guardianship in accordance with Chapter 744, Florida Statutes, or unmarried children where Enrollee was granted court-ordered temporary or other custody<br>• Children with a qualified medical support order requiring the Enrollee to provide coverage |
| **Children with intellectual or physical disabilities after they reach age 26 if:** | • They were enrolled before they turned 26 and remain covered or they were over the age of 26 at the time of the Enrollee's initial enrollment; and<br>• They are incapable of self-sustaining employment because of intellectual or physical disability;<br>• They are dependent on you for care and financial support; and<br>• The treating physician provides documentation supporting the intellectual or physical disability while the dependent is still covered under the Plan.<br>• You must submit documentation to the health plan you selected upon request for review and confirmation. Disability status is verified at least every five years. If you fail to provide the required documentation or your dependent no longer meets eligibility requirements, you may be liable for medical and prescription drug Claims or premiums back to the date you enrolled your dependent.<br>Enrollees who have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria may enroll that child in the Plan the **first time** they enroll in a State-sponsored Plan. |

| | |
|---|---|
| **Children ages 26 to 30 as over-age dependents if:** | • They are unmarried; and<br>• They have no dependents of their own; and<br>• They are a resident of Florida or a full-time or part-time student; and<br>• They have no other health insurance<br>You may cover your over-age dependent, defined as a child age 26-30, under an individual health policy for an additional monthly premium. You and your eligible over- age dependent must be enrolled in the same health plan. The amount of financial support you provide determines whether the monthly premium for coverage comes out of your paycheck pretax as an active employee or if you must mail in payment<br>post-tax. If you are interested in this program, please call the People First Service Center at (866) 663-4735 for more information. |
| **Dependent of a dependent - you may cover your dependent's newborn from** birth up to age 18 **months if:** | A newborn child born to a dependent while the dependent is covered under the Plan. The newborn must be added within 60 days of the birth. Coverage may remain in effect for up to 18 months or until the covered dependent is no longer covered. You may be asked to provide documentation for your eligible dependents. Failing to provide the required documentation may make you liable for medical and prescription Claims or premiums back to the date of enrollment. You must fax required documentation to (800) 422-3128 or mail to People First Service Center, P.O. Box 6830, Tallahassee, Florida 32314. Please include your People First ID number on the top right corner of each page of your fax or other documentation.<br>Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida. |
| **Enrollee's surviving spouse** | • The Enrollee's surviving spouse<br>• Eligible children of an Enrollee's surviving spouse |
| **Line of duty death** | • Children of law enforcement, probation, or correctional officers who were killed in the line of duty and who are attending a college or university beyond their 18th birthday. |

### Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

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

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

### Notification of change in status

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

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

## Starting coverage

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

## Stopping coverage

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

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

### When will your coverage end

Your coverage under this plan will end if:

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

### When dependent coverage ends

Dependent coverage will end if:

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

### What happens to your dependents if you die?

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

### Why would we end your coverage?

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

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

## Special coverage options after your coverage ends

### When coverage may continue under the plan

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

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

### Consolidated Omnibus Budget Reconciliation Act (COBRA)

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

The qualifying events are:

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

Talk with your employer if you have questions about COBRA or to enroll. For any additional Eligibility Questions please contact: People First Service Center, P.O. Box 6830, Tallahassee, FL 32314

- Phone: (866) 663-4735
- Web: peoplefirst.myflorida.com

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

Your coverage may be extended if you are totally disabled when coverage ends. Only the medical condition which caused the total disability is covered during your extension. You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is “totally disabled” if they can’t engage in most normal activities like a healthy person of the same age and gender.

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

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

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

- They were enrolled before they turned 26 and remain covered or they were over the age of 26 at the time of the Enrollee's initial enrollment; and
- They are incapable of self-sustaining employment because of intellectual or physical disability;
- They are dependent on you for care and financial support; and
- The treating physician provides documentation supporting the intellectual or physical disability while the dependent is still covered under the Plan. You must submit documentation to the health plan you selected upon request for review and confirmation. Disability status is verified at least every five years. If you fail to provide the required documentation or your dependent no longer meets eligibility requirements, you may be liable for medical and prescription drug Claims or premiums back to the date you enrolled your dependent.

Enrollees who have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria may enroll that child in the Plan the **first time** they enroll in a State-sponsored Plan

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

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

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

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

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

- You were covered at the time of your death
- The request is made within 31 days after your death, and
- Payment is made for coverage

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

- The end of the 24 month period after your death
- They no longer meet the definition of dependent
- Dependent coverage stops under the plan
- The dependent becomes covered by another health benefits plan
- The date your spouse remarries

To request extension of coverage, the dependent, or their representative, please call the People First Service Center at (866) 663-4735 for more information.

# General provisions – other things you should know

## Administrative provisions

### How you and we will interpret this booklet

We prepared this booklet according to federal and state laws that apply. You and we will interpret it according to these laws. Also, you are bound by our interpretation of this booklet when we administer your coverage.

### How Aetna administers this plan

Aetna will administer the Plan in accordance with this booklet and apply policies and procedures which Aetna has developed to administer this plan.

### Who's responsible to you

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

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

## Claim administrator

### Aetna's authority as claim administrator

Aetna has been delegated the authority to make claim and appeal determinations under the Plan. In exercising this responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

## Coverage and services

### Your coverage can change

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

### Physical examination and evaluations

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

### Records of expenses

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

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

## Honest mistakes and intentional deception

### Honest mistakes

You or the Customer/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 contributions 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:

- Rescission of coverage
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities. See the *Benefit payments and claims, Filing a claim* section for information about rescission.

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage
- You have the right to an appeal
- You have the right to a third party review conducted by an independent ERO

## Some other money issues

### Legal action

You must complete the internal appeal process, if your plan has one, before you take any legal action against us for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section.
You cannot take any action until 60 days after we receive written submission of a claim.

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

### Assignment of benefits

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

### Financial sanctions exclusions

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx

### Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

## SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

### Subrogation

The right of subrogation means the plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the plan. Immediately upon paying or providing any benefit under the plan, the plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

### Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

### Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

**Lien Rights**
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the plan.

**Assignment**
In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

**First-Priority Claim**
By accepting benefits from the plan, you acknowledge that the plan's recovery rights are a first priority claim and are to be repaid to the plan before you receive any recovery for your damages. The plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

**Applicability to All Settlements and Judgments**
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's claim will not be reduced due to your own negligence.

**Cooperation**
You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

You acknowledge that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share your personal health information in exercising its subrogation and reimbursement rights.

**Interpretation**
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

**Jurisdiction**
By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

## Your health information

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

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

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

# Glossary

## Behavioral health provider

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

## Brand-name prescription drug

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

## Copay, copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

## Covered services

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

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

## Deductible

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

## Detoxification

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

## Emergency medical condition

An acute symptom of sufficient severe medical condition that:

- Needs immediate medical care
- Severe pain
- Leads a person who possesses an average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby

## Emergency services

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

## Experimental or investigational

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

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

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

## Generic prescription drug

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

- Dosage
- Safety
- Strength
- Quality
- Performance

## Health professional

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

## Home health care agency

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

## Hospital

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

## Infertility

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

- For an individual or their partner who has been clinically diagnosed with gender dysphoria

## Jaw joint disorder

This is:

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

## Mail order pharmacy

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

## Maximum out-of-pocket limit

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

## Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your **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 your illness, injury or disease.

Generally accepted standards of medical practice mean:

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

**Important note:**
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *Contact us* section for how.

## Mental health disorder

A **mental health disorder** is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of **mental health disorder** is in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association*.

## Negotiated charge

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

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

## Out-of-network provider
A **provider** who is not a **network provider.**

## Payment Percentage
The specific percentage the plan pays for a health care service listed in the schedule of benefits.

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

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

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

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

- The directory lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to a covered person
- Shows in our records as your **PCP**

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

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

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

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

## Residential treatment facility

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

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

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

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

For residential treatment programs treating **substance related disorders**:

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

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

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

## Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs. Retail pharmacy provided by Optum. Please see Optum pharmacy documents for specific details of coverage.

## Room and board

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

## Semi-private room rate

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

## Skilled nursing facility

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

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

**Skilled nursing facility** does not include institutions that provide only:

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

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

## Specialist

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

## Stay

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

## Substance related disorder

The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association, that directly affect the brain's reward system in an amount or frequency that causes problems with normal activities.

## Surgery, surgical procedure

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

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

## Telemedicine

A consultation between you and a **physician**, **specialist**, **behavioral health provider**, or **telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication.

## Terminal illness

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

## Walk-in clinic

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

- Drug store
- Pharmacy
- Retail store
- Supermarket

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

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

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

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

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

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

## Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

# IMPORTANT HEALTH CARE REFORM NOTICES

### CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

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

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior 3written agreement between Aetna and your Employer.

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

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

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

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

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

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

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

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

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

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

**Coverage Continuation When You Are Off Payroll**
If you are an active employee and go off the payroll (e.g. military leave), you must pay your share of the health insurance premium by personal check, cashier's check, or money order to continue coverage. You may be required to pay the full premium cost (your share plus the state's share) depending on the reason you are not working. Call People First for more information at (866) 663-4735.

If you do not want to continue insurance coverage while off the payroll, you must call People First to cancel within 60 days of your leave date. This notice ensures you can re-enroll in coverage upon returning to work. If you do not cancel and are later cancelled because you did not pay the health insurance premium, you will only be allowed to enroll during the next Open Enrollment.

**Converting Health Insurance Plan Coverage to a Private Policy**
If coverage under the Plan ends for you or your eligible dependents for reasons other than your choice to cancel coverage or your failure to pay your share of the premium cost, you may convert to a private policy. You must apply in writing to Aetna and pay the first month's premium within 63 days of the date your group coverage ended. When you convert, you will have the standard HMO conversion policy. The benefits provided by the conversion policy may be different from the benefits provided under the State Employees' HMO Plan. If you choose COBRA continuation coverage when your Plan coverage ends, you can convert to a private policy when COBRA coverage ends. In this case, you must still apply in writing and pay the first month's premium within 63 days of the date your COBRA coverage ends. Call Aetna at the number listed in the contact section within this document for information.

**Continuation of Benefits if you are Disabled**
If you or your Health Plan Member is totally disabled at the time your Plan coverage ends, the Plan will continue to pay benefits for Covered Services and Supplies that are directly related to the disability if:

1. The disability is a result of a covered illness or accident; and

2. The Plan's Claims administrator determines that you or your eligible dependent is totally disabled at the time coverage ends.

For this continuation of benefits, total disability means:
1. For an employee: you are unable to perform any work or occupation for which you are reasonably qualified and trained; or

2. For a dependent, Retiree or Surviving Spouse: the person is unable to engage in most normal activities of someone the same age and sex who is in good health.

This extension of benefits is provided at no cost to you and can continue if you do not have any other insurance to cover this loss:

1. As long as total disability lasts, up to a maximum of 12 months; or

2. Until you become covered by another plan providing similar benefits, whichever occurs first. COBRA coverage will not be available if this coverage is selected.

**Extension of Benefits if the Plan is Terminated**
If the Plan is ever terminated, benefits will be extended for the following reasons only:

1. If you are in the Hospital when the Plan is terminated, your Covered Services and Supplies will be eligible for payment for 90 days following Plan termination.

2. If you are pregnant when the Plan is terminated, covered maternity benefits will continue to be paid for the rest of your pregnancy.

3. If you are receiving covered Dental Care when the Plan is terminated, benefits will continue to be paid for 90 days following Plan termination or until you become covered under another policy providing coverage for similar dental procedures, as long as the Dental Care is recommended in writing by your doctor or dentist and is for the treatment of a covered illness or accident. Both the illness or accident and the treatment recommendation must occur prior to termination of the Plan. These extended dental benefits do not include coverage for routine examinations, prophylaxis, x-rays, sealants, orthodontic services, or Dental Care that is not covered.

## Schedule of benefits

**Prepared for:**

| | |
|---|---|
| Employer: | State of Florida - Department of Management Services (dms) |
| Contract number: | ASA-0326415 |
| Plan name: | Open Access Aetna Select |
| Schedule of benefits: | 1A |
| Plan effective date: | January 1, 2024 |
| Plan issue date: | January 19, 2024 |

**Third Party Administrative Services provided by Aetna Life Insurance Company**

# Schedule of benefits

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

## How your cost share works

- The **deductibles** and **copayments**, if any, listed in the schedule below are the amounts that you pay for **covered services**.
  - For the **covered services** under your medical plan, you will be responsible for the dollar amount
  - For pharmacy benefits where a percentage cost share acts like a **copayment**, you will be responsible for the percentage amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount **copayment** that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, **copayments** and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
  - Based on a rolling, 12 month period starting with the date of your most recent visit under this plan

  See the schedule for more information about limits.
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at https://www.aetna.com/

**Important note:**
**Covered services** are subject to the **deductible**, maximum out-of-pocket, limits, **copayment** or **payment percentage** unless otherwise stated in this schedule. The *Surprise bill* section in the booklet explains your protections from a surprise bill.

Under this plan, you will:

1. Pay your **copayment**

## How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

## How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

## Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

## Plan features

### Per admission copayment

| Per admission copayment type | In-network |
|---|---|
| Per admission **copayment** | $250 per admission |

### Maximum out-of-pocket limit

Excludes the **deductible**.

| Maximum out-of-pocket type | In-network |
|---|---|
| Individual | $1,500 per year |
| Family | $3,000 per year (not to exceed $1,500 per health plan member) |

### Global out-of-pocket limit

Includes covered expenses for medical and prescription drugs.

| Maximum out-of-pocket type | In-network |
|---|---|
| Individual | $9,450 per year |
| Family | $18,900 per year (not to exceed $9,450 per health plan member) |

## General coverage provisions

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

## Global Out of Pocket limit

There is a limit on the amount you pay out of your pocket toward covered expenses in any one calendar year for network covered services, supplies and prescription drugs. Once your share of the global out-of-pocket limit reaches the annual limit, this plan begins paying 100 percent of the claims for network health plan covered services which include services, supplies and prescription drugs for the remainder of the calendar year for you.

If you have individual coverage, the plan begins paying all your eligible expenses after you meet your individual global out-of-pocket limit.

If you have family coverage, when one Health Plan Member in a family contract pays the individual global out-of-pocket amount for network medical services, supplies, and prescription drugs, the plan starts paying 100 percent for that health plan member (called embedded) for the remaining calendar year. Thus, the balance of the family out-of-pocket amount may be paid by another or combination of remaining family members up to the family out-of-pocket max amount.

Only expenses from Network Covered Services and Supplies and prescription drugs count toward the global out-of-pocket maximum. Expenses that apply to this maximum include applicable cost share until the aggregate out- of-pocket limit is met. Preventive services are paid at 100 percent when provided by Participating Providers.

Expenses that do not apply to the global Network out-of-pocket limit:
1. Premiums;

2. Prescription drug brand name additional charges;

3. Charges for services, supplies and prescription drugs that are not covered by this Plan;

4. Charges for Covered Services and Supplies and prescription drugs that are greater than Plan limits on dollar amounts, number of treatments, or number of days of treatment;

5. Specialty drugs that are denied by the Specialty Guideline Management Program;

6. Specialty drugs that would have been denied or would have been outside clinical treatment guidelines by the Specialty Guideline Management Program if you had tried to get the drug approved but did not go through the proper approval process; and,

7. The difference between the cost of the generic drug and brand name drug when the prescribing physician does not indicate “dispense as written” or “brand name Medically Necessary” and you request the brand name drug.

Remember to confirm with your Participating Provider before services are rendered that any required preauthorization for services has been obtained from Aetna. Also, services performed beyond the scope of practice authorized for that provider under State law will be denied unless otherwise expressly authorized under the terms of the Plan or when required to treat an Emergency Medical Condition. Except for Emergency Medical Services and Care, all services must be received from Participating Providers. Any Health Plan Member requiring medical, Hospital or ambulance services for emergencies as described in the Definitions section, either while temporarily outside the Service Area or within the Service Area but before they can reach a Participating Provider, may receive emergency benefits.

## Copayment
This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit.

## Per admission copayment
This is the amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility.

## Payment Percentage
This is the percentage of the bill you pay after you meet your **deductible**.

## Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**.

### Individual maximum out-of-pocket limit
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.

- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

### Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-**covered services** which are identified in the booklet and the schedule

Costs for non-urgent use of an urgent care **provider**

## Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

## Covered services

### Ambulance services

| Description | In-network |
|---|---|
| **Emergency services** | 100% per trip, no **deductible** applies |
| Non-**emergency services** | Not covered |

### Applied behavior analysis

| Description | In-network |
|---|---|
| Applied behavior analysis | Covered based on type of service and where it is received |

### Autism spectrum disorder

| Description | In-network |
|---|---|
| Diagnosis and testing | Covered based on type of service and where it is received |
| Treatment | Covered based on type of service and where it is received |
| Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder | Covered based on type of service and where it is received |

## Behavioral health

### Mental health treatment

Coverage provided is the same as for any other illness

| Description | In-network |
|---|---|
| Inpatient services-**room and board** including **residential treatment facility** | $250 then the plan pays 100% per admission, no **deductible** applies |
| Other inpatient services and supplies<br>Other **residential treatment facility** services and supplies | 100% per admission, no **deductible** applies |

| Description | In-network |
|---|---|
| Outpatient office visit to a **physician** or **behavioral health provider** | $20 then the plan pays 100% per visit, no **deductible** applies |
| **Physician** or **behavioral health provider telemedicine** consultation | $20 then the plan pays 100% per visit, no **deductible** applies |
| Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received |

| Description | In-network |
|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Telemedicine provider mental health disorders** consultation | Covered based on type of service and **provider** from which it is received |
| **Telemedicine** cognitive therapy **mental health disorders** consultation by a **telemedicine provider** | Covered based on type of service and **provider** from which it is received |

**Substance related disorders treatment**

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

| Description | In-network |
|---|---|
| Inpatient services-**room and board** during a **hospital stay** | $250 then the plan pays 100% per admission, no **deductible** applies |
| Other inpatient services and supplies during a **hospital stay** | 100% per admission, no **deductible** applies |
| **Description** | **In-network** |
| Outpatient office visit to a **physician** or **behavioral health provider** | $20 then the plan pays 100% per visit, no **deductible** applies |
| **Physician** or **behavioral health provider telemedicine** consultation | $20 then the plan pays 100% per visit, no **deductible** applies |
| Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider** | Covered based on type of service and **provider** from which it is received |

| Description | In-network |
|---|---|
| Other outpatient services including:<br>• Behavioral health services in the home<br>• Partial hospitalization treatment<br>• Intensive outpatient program<br><br>The cost share doesn't apply to in-network peer counseling support services | 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Telemedicine provider substance related disorders** consultation | Covered based on type of service and **provider** from which it is received |
| **Telemedicine** cognitive therapy **substance related disorders** consultation by a **telemedicine provider** | Covered based on type of service and **provider** from which it is received |

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

| Description | In-network |
|---|---|
| Diabetic services | Covered based on type of service and where it is received |
| Diabetic supplies | Covered based on type of service and where it is received |
| Diabetic equipment | Covered based on type of service and where it is received |
| Diabetic self-care programs | Covered based on type of service and where it is received |

## Durable medical equipment (DME)

| Description | In-network |
|---|---|
| DME | 100% per item, no **deductible** applies |

### Emergency services

| Description | In-network | Out-of-network |
|---|---|---|
| Emergency room | $100 then the plan pays 100% per visit, no **deductible** applies, copay waived if admitted | Paid same as in-network |
| Non-emergency care in a **hospital** emergency room | $100 then the plan pays 100% per visit, no **deductible** applies, copay waived if admitted | Not covered |

**Emergency services important note: Out-of-network providers** do not have a contract with us. However, for out of network emergencies the federal No Surprises Act applies. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

## Foot orthotic devices

| Description | In-network |
|---|---|
| Orthotic devices | 100% per item, no **deductible** applies |

### Habilitation therapy services

#### Outpatient physical (PT), occupational (OT) therapies

| Description | In-network |
|---|---|
| PT, OT therapies | Covered based on type of service and where it is received |

#### Outpatient speech therapy (ST)

| Description | In-network |
|---|---|
| ST therapy | Covered based on type of service and where it is received |

## Hearing exams

| Description | In-network |
|---|---|
| Hearing exams | Covered based on type of service and where it is received |
| Visit limit | Unlimited |

## Home health care

A visit is a period of 4 hours or less

| Description | In-network |
|---|---|
| Home health care | 100% per visit, no **deductible** applies |

**Home health care important note:**
Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

## Hospice care

| Description | In-network |
|---|---|
| Inpatient services - **room and board** | $250 then the plan pays 100% per admission, no **deductible** applies |

| Description | In-network |
|---|---|
| Other inpatient services and supplies | 100% per admission, no **deductible** applies |

| | |
|---|---|
| Day limit per lifetime | 210 |

| Description | In-network |
|---|---|
| Outpatient services | 100% per visit, no **deductible** applies |

| | |
|---|---|
| Limit per lifetime | combined with inpatient |

**Hospice important note:**
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day. Massage therapy included while performed during a hospice setting.

## Hospital care

| Description | In-network |
|---|---|
| Inpatient services - **room and board** | $250 then the plan pays 100% per admission, no **deductible** applies |

| Description | In-network |
|---|---|
| Other inpatient services and supplies | 100% per admission, no **deductible** applies |

## Jaw joint disorder

Includes TMJ

| Description | In-network |
|---|---|
| **Jaw joint disorder** treatment | Covered based on type of service and where it is received |

## Maternity and related newborn care

Includes complications

The cost share and **deductible** amount for newborns is waived for nursery charges during the newborn's initial routine **stay**. The nursery charges will apply for non-routine facility **stays**.

| Description | In-network |
|---|---|
| Inpatient services – **room and board** | $250 then the plan pays 100% per admission, no **deductible** applies |
| Other inpatient services and supplies | 100% per admission, no **deductible** applies |
| Services performed in **physician** or **specialist** office or a facility | 100% per visit, no **deductible** applies |
| Other services and supplies | 100% per visit, no **deductible** applies |

**Maternity and related newborn care important note:**
Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the booklet. It will give you more information about coverage for maternity care under this plan.

### Nutritional support

| Description | In-network |
|---|---|
| Nutritional support | Covered based on type of service and where it is received |

### Oral and maxillofacial treatment (mouth, jaws and teeth)

| Description | In-network |
|---|---|
| Treatment of mouth, jaws and teeth | Covered based on type of service and where it is received |

### Outpatient Surgery

| Description | In-network |
|---|---|
| At **hospital** outpatient department | 100% per visit, no **deductible** applies |
| At facility that is not a **hospital** | 100% per visit, no **deductible** applies |
| At the **physician** office | Covered based on type of service and where it is received |

## Physician and specialist services

### Physician services-general or family practitioner

| Description | In-network |
|---|---|
| **Physician** office hours (not-surgical, not preventive) | $20 then the plan pays 100% per visit, no **deductible** applies |
| **Physician** surgical services | $20 then the plan pays 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Physician** visit during inpatient **stay** | 100% per visit after **deductible** |

| Description | In-network |
|---|---|
| **Physician telemedicine** consultation | $20 then the plan pays 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Telemedicine provider** consultation<br><br>Basic medical services | Covered based on type of service and **provider** from which it is received |

## Specialist

| Description | In-network |
|---|---|
| **Specialist** office hours (not surgical, not preventive) | $40 then the plan pays 100% per visit, no **deductible** applies |
| **Specialist** surgical services | $40 then the plan pays 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Specialist telemedicine** consultation | $40 then the plan pays 100% per visit, no **deductible** applies |

| Description | In-network |
|---|---|
| **Telemedicine provider** consultation<br><br>**Specialist** services | Covered based on type of service and **provider** from which it is received |

## Preventive care

| Description | In-network |
|---|---|
| Preventive care services | 100% per visit, no **deductible** applies |
| Breast feeding counseling and support | 100% per visit, no **deductible** applies |
| Breast feeding counseling and support limit | 6 visits in a group or individual setting<br><br>Visits that exceed the limit are covered under the **physician** services office visit |
| Breast pump, accessories and supplies limit | Manual pump: 1 per pregnancy<br><br>Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump |
| Counseling for alcohol or drug misuse | 100% per visit, no **deductible** applies |
| Counseling for alcohol or drug misuse visit limit | 5 visits/12 months |

| | |
|---|---|
| Counseling for obesity, healthy diet | 100% per visit, no **deductible** applies |
| Counseling for obesity, healthy diet visit limit | Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. |
| Counseling for sexually transmitted infection | 100% per visit, no **deductible** applies |
| Counseling for sexually transmitted infection visit limit | 2 visits/12 months |
| Counseling for tobacco cessation | 100% per visit, no **deductible** applies |
| Counseling for tobacco cessation visit limit | 8 visits/12 months |
| Family planning services (female contraception counseling) | 100% per visit, no **deductible** applies |
| Family planning services (female contraception counseling) limit | Contraceptive counseling limited to 2 visits/12 months in a group or individual setting |
| Immunizations | 100%, no **deductible** applies |
| Immunizations limit | Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** |
| Preventive care risk reducing breast cancer **prescription** drugs | 100% |
| Preventive care risk reducing breast cancer **prescription** drugs limit | Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF<br><br>For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section |
| Routine cancer screenings | 100% per visit, no **deductible** applies |
| Routine cancer screening limits | Subject to any age, family history and frequency guidelines as set forth in the most current:<br>Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF<br><br>The comprehensive guidelines supported by the Health Resources and Services Administration<br><br>For more information contact your **physician** or see the *Contact us* section |
| Routine lung cancer screening | 100% per visit, no **deductible** applies |

| | |
|---|---|
| Routine lung cancer screening limit | 1 screening every 12 months<br><br>Screenings that exceed this limit covered as outpatient diagnostic testing |
| Routine physical exam | 100% per visit, no **deductible** applies |
| Routine physical exam limits | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents<br><br>Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 18; 1 exam every 12 months after age 22<br><br>High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months |
| Well woman GYN exam | 100% per visit, no **deductible** applies |
| Well woman GYN exam limit | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration |

## Private duty nursing

Up to 8 hours equals one shift

| Description | In-network |
|---|---|
| Outpatient services | 100% per visit, no **deductible** applies |

## Prosthetic devices

| Description | In-network |
|---|---|
| Prosthetic devices | 100% per item, no **deductible** applies |
| Wigs | $40 maximum per condition |

## Reconstructive surgery and supplies

Including breast **surgery**

| Description | In-network |
|---|---|
| Surgery and supplies | Covered based on type of service and where it is received |

## Short-term rehabilitation services

A visit is equal to no more than 1 hour of therapy.

### Pulmonary Rehabilitation

| Description | In-network |
|---|---|
| Pulmonary rehabilitation | Covered based on type of service and where it is received |

### Cognitive Rehabilitation

| Description | In-network |
|---|---|
| Cognitive Rehabilitation | Covered based on type of service and where it is received |

**Physical, Occupational and Speech Therapies**

| Description | In-network |
|---|---|
| | $40 then the plan pays 100% per visit; no **deductible** applies |

**Physical, occupational and speech therapies**

| Description | In-network |
|---|---|
| Visit limit per year and condition<br><br>Physical, spinal and speech therapies combined | 60 |
| Occupational therapy | 60 |

**Spinal Manipulation**

| Description | In-network |
|---|---|
| | $40 then the plan pays 100% per visit, no **deductible** applies |

| | |
|---|---|
| Visit limit per year | combined with Physical and Speech therapies |

**Skilled nursing facility**

| Description | In-network |
|---|---|
| Inpatient services - **room and board** | $250 then the plan pays 100% per admission, no **deductible** applies |
| Other inpatient services and supplies | 100% per admission, no **deductible** applies |

| | |
|---|---|
| Day limit per Calendar year | 60 |

## Tests, images and labs – outpatient

**Diagnostic complex imaging services**

| Description | In-network |
|---|---|
| | 100% per visit, no **deductible** applies |

**Diagnostic lab work**

| Description | In-network |
|---|---|
| | 100% per visit, no **deductible** applies |

### Diagnostic x-ray and other radiological services

| Description | In-network |
|---|---|
| | 100% per visit, no **deductible** applies |

## Therapies

### Chemotherapy

| Description | In-network |
|---|---|
| Chemotherapy services | Covered based on type of service and where it is received |

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

| Description | In-network (GCIT-designated facility/provider) | Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**) |
|---|---|---|
| Services and supplies | Covered based on type of service and where it is received | Not covered |
| Gene therapy products, **prescription** drugs | $40 then the plan pays 100% per visit, no **deductible** applies | Not covered |

### Infusion therapy

Outpatient services

| Description | In-network |
|---|---|
| In **physician** office | $20 then the plan pays 100% per visit, no **deductible** applies, copay waived if no office visit is billed with these services |
| In **specialist** office | $40 then the plan pays 100% per visit, no **deductible** applies, copay waived if no office visit is billed with these services |
| At an infusion location | Covered based on type of service and where it is received |
| In the home | 100% per visit, no **deductible** applies |
| At **hospital** outpatient department | 100% per visit, no **deductible** applies |
| At facility that is not a **hospital** | 100% per visit, no **deductible** applies |

### Radiation therapy

| Description | In-network |
|---|---|
| Radiation therapy | Covered based on type of service and where it is received |

### Respiratory therapy

| Description | In-network |
|---|---|
| Respiratory therapy | Covered based on type of service and where it is received |

## Transplant services

| Description | In-network (IOE facility) |
|---|---|

| | |
|---|---|
| Inpatient services and supplies | $250 then the plan pays 100% per transplant, no **deductible** applies |
| **Physician** services | Covered based on type of service and where it is received |

## Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

| Description | In-network |
|---|---|
| Urgent care facility | $25 then the plan pays 100% per visit, no **deductible** applies |

| | |
|---|---|
| Non-urgent use of an urgent care facility or **provider** | Not covered |

## Vision care

Performed by an ophthalmologist or optometrist and includes refraction

| Description | In-network |
|---|---|
| | Covered based on type of service and where it is received, copay applies ($20 PCP, $40 Specialist) |

| | |
|---|---|
| Visit limit | 1 visit every 12 months |

## Virtual primary care

Telemedicine consultation

| Description | In-network |
|---|---|
| Preventive care consultations | $20 then the plan pays 100% per visit, no deductible applies |
| All other basic medical services consultations | $20 then the plan pays 100% per visit, no deductible applies |
| Routine physical checkup limit | 1 virtual visit every year |

## Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

| Description | In-network |
|---|---|
| Non-**emergency services** | $25 then the plan pays 100% per visit, no **deductible** applies |
| Preventive care immunizations | 100% per visit, no **deductible** applies |
| Preventive care immunization limits | Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention<br><br>For details, contact your **physician** |
| Preventive screening and counseling services | 100% per visit, no **deductible** applies |
| Preventive screening and counseling limits | See the *Preventive care services* section of the SOB |