Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-844-365-7374 (TTY: 711).

Smartphone or Tablet

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

Non-Discrimination

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

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation Banner|Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently or other services, call the number on your ID card.

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

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512,

1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Banner|Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Each insurer has sole financial responsibility for its own products. Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. are affiliates of Banner Health and, of Aetna and its affiliates (Aetna). Aetna provides certain management services to Banner|Aetna.

Language Assistance

TTY:711

English To access language services at no cost to you, call the number on your ID card.

Spanish Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.

Navajo T’11 ni nizaad k’ehj7 bee n7k1 a’doowo[doo b33h 7l7n7g00 naaltsoos bee atah n7l98go nanitin7g77 bee n44ho’d0lzin7g77 b44sh bee hane’7 bik1’7g77 1aj8’ h0lne’.

Chinese Traditional 如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼

Vietnamese Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

Arabic للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.

Tagalog Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

Korean 무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.

French Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.

German Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.

Russian Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.

Japanese 無料の言語サービスは、IDカードにある番号にお電話ください。

Persian Farsi برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.

Syriac-Assyrian ܠܡܛܥܢܝܬ ܫܘܬܦܘܬܐ ܒܠܫܢܐ ܕܠܐ ܡܨܪܝ ܥܠ ܐܝܟ ܡܫܬܡܫ ܒܡܠܦܢ ܕܒܛܘܦܣ ܕܒܟܪܛܝܣ ܕܐܝܕܝ ܕܐܝ ܗܘ ܡܟܬܘܒ ܥܠ ܟܪܛܝܣ ܕܐܝܕܝ ܕܐܝ ܗܘ ܡܟܬܘܒ.

Serbo-Croatian Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.

Thai หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย
โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน

Health maintenance organization (HMO) policy

2023 AZ BannerAetna Silver: HMO CSR 87 ON Standard

This policy is by and between Banner Health and Aetna Health Plan Inc. (Banner|Aetna, we, us, or our) and the policyholder (you, your).

Coverage starts on your effective date of coverage and continues until it ends as described in this policy.

Your policy provides coverage for services and supplies that are **covered services**. It describes your coverage only. You may get health care services or **prescription** drugs that might not be **covered services** under your policy. Please read your policy and the schedule of benefits because they explain your benefits in detail.

Health benefits and health insurance plans are offered, underwritten, and/or administered by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Banner|Aetna is an affiliate of Banner Health and of Aetna Life Insurance Company and its affiliates (Aetna). Each insurer has sole financial responsibility for its own products. Aetna and Banner Health provide certain management services to Banner|Aetna. Aetna is part of the CVS Health family of companies.

Read your policy carefully

Your policy is a legal contract between you and us. We agree to cover you under this policy in return for your premium payments. We will pay eligible **covered services** while this policy is in force and after the policy conditions are met.

Right to examine the policy

You have 10 days after you receive this policy to read and review it. During that 10-day period, if you decide you don't want the policy, you may return it to us or to the agent who sold it to you. As soon as it is returned, this policy will be void from the beginning. Premium paid will be paid back.

Guaranteed renewable

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

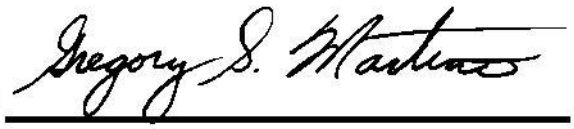
You may keep this policy in force by meeting the policy requirements and by paying the premium on time. See the *What does the policy cost you?* section of the policy for more information.

Your application

By applying for coverage under this policy, or accepting its benefits, you (or the person acting for you) represent that all information in your application and statements given as part of your application for this policy are true, correct and complete, to the best of your knowledge and belief; and you agree to all terms, conditions and provisions of the policy.

It is your responsibility to make sure the application that you submitted is accurate and complete. It is important that you notify us or, if you applied through the Health Insurance Marketplace (the Marketplace), the Marketplace immediately of any mistakes that you find in your application.

If we learn that you defrauded us or you intentionally misrepresented material facts when you gave information and answers in the application, or in the application process, we may decide to cancel the policy. We may also report fraud to criminal authorities. Please see the *Honest mistakes and intentional deception* topic in the *General provisions – other things you should know* section of this policy for more information.

By: 

Gregory S. Martino
Vice President

Table of contents

Welcome

At Banner|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 Banner|Aetna.

Introduction

This is your policy. It describes your **covered services** – what they are and how to get them. The second document is the schedule of benefits. It tells you how we share expenses for **covered services** and explains any limits – like when your policy covers only a certain number of visits.

How we use words

When we use:

- "You" and "your" we mean you as the policyholder and any covered dependents, if dependent coverage is available under the policy
- "Us," "we," and "our" we mean Banner|Aetna
- Words that are in bold, we define them in the *Glossary* section

Contact us

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

- Calling the toll-free number on your ID card
- Writing us at PO Box 14079 Lexington, KY 40512-4079
- Visiting https://www.banneraetna.com to register and access your member website

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

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this policy. Show your ID card each time you get **covered services** from a **provider.**

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

To get your digital ID card, log in to our website. You can also print your ID card. See the *Contact us* section for help.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as a Banner|Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment**, **deductible** or **coinsurance** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

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.

What does the policy cost you?

Premium payment

This policy requires you to make premium payments. We will not pay benefits under this policy for services obtained after coverage ends if premium payments are not made by the end of the grace period. Any benefit payment denial is subject to our appeals procedure. See the *Complaints, claim decisions and appeal procedures* section of this policy.

The first premium payment is due on or before your effective date of coverage. When we calculate the premium you owe, we use our records to determine who is covered under the policy. You owe premium for each person covered under the policy starting with the first premium due date on or after the day the person's coverage starts. You stop paying premium as of the first premium due date on or after the day the person's coverage ends.

After your first premium payment is made, premium payments are due on the 1st or 15th of each month based on your effective date of coverage. Each premium payment is to be paid to us on or before the due date. Your premium becomes overdue after the last day of the premium period.

We provide this policy to you and you pay premium to us. We may choose not to accept premium that is paid for you by someone else unless we are required to by applicable law.

Grace period

You have a grace period of 31 days after the due date for the payment of each premium due after the first premium payment. If premiums are not paid by the end of the grace period, your coverage will automatically terminate at the last date for which premium was paid, or as of the date required by applicable law.

We have the right to require the return of any payments for claims paid during the grace period for which premium was not received.

Important note:
If you are currently getting advanced payments of the premium tax credit, as determined by the Marketplace, the grace period above does not apply to you. Instead, the following applies:

If you are getting advance payment of the premium tax credit now, and you have paid at least one full month's premium as your binder payment, when applicable:

- You will have a grace period of three months
- Your coverage will not end during the grace period

If you receive services during the second and third months of the grace period:

- We may wait to pay claims until the premium is paid
- We will tell you and your **providers** that you are within your grace period

If premium is not paid by the end of the three month period:

- Your coverage may end
- Your coverage will end on the last day of the first month of the grace period
- We may take back payment for any claims paid during the second and third months of the grace period

Reinstatement

We can end this policy because you have not paid your premium. If this happens, we can reactivate ("reinstate") the policy without a break in coverage. You must ask us to do so within 30 days of the policy end date. But, for us to do this, you must pay us the total premium you already owe plus the new premium. We can decide not to reinstate the policy.

Premium agreement

Your premium rate will not change during the policy term as long as there are no changes to this policy. Changes include things like the area you live in, the benefit plan or adding dependents to the policy.

Your premium rate is based on factors such as:

- The policy in which you are enrolled
- Your age and the ages of covered dependents
- The number of covered persons
- Tobacco use
- Where you live (primary address)

Each premium will be based on the rates that apply on that premium due date.

In the event of any changes in premium rates, payment of the premium by you means that you accept the premium changes.

Coverage and exclusions

Providing covered services

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

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

This policy 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 policy 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 it is a **covered service** only up to a set number of visits a year. This is a limitation that would be shown in your schedule of benefits
- 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 policy 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 policy 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 manual or electro acupuncture.

The following is not a **covered service**:

- 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 the process of applying interventions that:

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

Important note:
Applied behavior analysis may require **precertification** by us. See the *How your policy works – Medical necessity and precertification* section.

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 voluntary or court-ordered 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 policy 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 (includes **telemedicine** consultation)

Substance related disorders treatment

Covered services include the voluntary or court-ordered 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 policy 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**
    - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (includes **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. In this section approved clinical trials means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

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)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

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
  - Foot orthotics
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors (including those with special features when 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 policy only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your policy 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 medically necessary.

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
- Compression garments for treatment of lymphedema

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 providers** 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
- Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your policy 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 policy will not cover your expenses.

Family planning services – other

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

- Abortion to the extent the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

The following are not covered under this benefit:

- 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

Gender affirming treatment

Covered services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

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

Habilitation therapy services

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

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 aids

Hearing aid means:

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

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology

    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- New or replacement hearing aids no longer under warranty (Pre-Certification/Prior Authorization required)
- Cleaning or repair
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen, or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords except those for cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

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

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**

Home health care

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

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

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 *Short-term rehabilitation services* r*ehabilitation 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

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not employees 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 policy will cover the extra expense of a private room and/or private duty nursing 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 blood or blood product.
- Dialysis care outpatient and inpatient

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

Anesthesia and hospital charges for dental care

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

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**.

Infertility services exclusions

The following are not **covered services**:

- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
- Home ovulation prediction kits or home pregnancy tests

- Injectable **infertility** medication, including but not limited to menotropins, hCG and GnRH agonists
- The purchase of donor embryos, donor oocytes or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Any charges associated with obtaining sperm from a person not covered under this policy for ART services
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Jaw joint disorder treatment

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

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)
- Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral)

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

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

The following are not **covered services**:

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

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

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

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

Nutritional evaluations

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

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

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

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. Enteral nutrition when medically necessary for the treatment of Eosinophilic Gastrointestinal Disorder and inherited metabolic disease

The following are not **covered services**:

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

Obesity (bariatric) surgery

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

Covered services include:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- One obesity **surgical procedure**
- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services**:

- Weight management treatment.
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the policy.
- 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.

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 policy 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 and **telemedicine** visits are **covered services** with a **behavioral health provider**

Telemedicine may have 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

Physician surgical services

Covered services include the services of:

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

The following are not **covered services**:

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

Prescription drugs - outpatient

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

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

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

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

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

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

Prescription drug synchronization

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

How to access network pharmacies

You can find a network pharmacy either online or by phone. See the *Contact us* section for help. You may go to any of our network pharmacies. If you don't get your **prescriptions** at a network pharmacy, your **prescriptions** will not be a **covered service** under the policy. Pharmacies include **network retail**, **mail order** and **specialty pharmacies**.

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

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

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of **prescription** drugs.
A network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit. All **prescriptions** and refills for more than a 30 day supply must be filled at a network **mail order pharmacy.**

Mail order pharmacy

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

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

Specialty pharmacy

Specialty prescription drugs are covered when dispensed through a network **specialty pharmacy**. **Specialty prescription drugs** typically include high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected ways of giving them. You can access the list of **specialty prescription drugs**. See the *Contact us* section for help.

All **specialty prescription drug** fills including the initial fill must be filled at a network **specialty pharmacy** unless it is an urgent situation. **Specialty prescription drugs** may fall under various drug tiers regardless of their names. See the schedule of benefits for details on supply limits and cost sharing.

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

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

What if the pharmacy you use leaves the network

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

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share is
A network pharmacy	The policy cost share
Out-of-network pharmacy	The full cost of the **prescription**

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

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

Other covered services

Anti-cancer drugs taken by mouth, including chemotherapy drugs

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

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. Your outpatient **prescription** drug plan also covers related services and supplies needed to administer covered devices. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices at https://www.fda.gov/consumers/free-publications-women/birth-control-chart.

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

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

Diabetic supplies and insulin

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors

- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

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

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

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

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:
- Increased risk for breast cancer
- Low risk for medication side effects

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

Outpatient prescription drugs exclusions
The following are not **covered services**:
- Abortion drugs
- Allergy serum and extracts administered by injection
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids unless specified on the **drug guide**
- Cosmetic drugs
  - Medications or preparations used for cosmetic purposes
- Compound **prescriptions** containing bulk chemicals that have not been approved by the U.S. FDA, including compounded bioidentical hormones
- Devices, products and appliances, except those that are specifically covered
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or dispensed
  - Which do not, by federal or state law, require a **prescription** order (i.e., over-the-counter (OTC) drugs), even if a **prescription** is written, except where stated above
  - That are therapeutically equivalent or a therapeutic alternative to a covered **prescription** drug unless a medical exception is approved
  - Provided under your medical benefits while an inpatient of a healthcare facility

  - Recently approved by the FDA, but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state or government agency (for example: Medicaid or Veterans Administration)
  - Not approved by the FDA or not proven to be safe and effective
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy (e.g., two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents, except as specifically provided above
- Implantable drugs and associated devices except where stated above
- **Infertility**
  - **Prescription** drugs used primarily for the treatment of **infertility**
- Injectables:
  - Any charges for the administration or injection of **prescription** drugs or injectable insulin and other injectable drugs covered by us.
  - Needles and syringes, except those used for insulin administration.
  - For any drug, which due to its characteristics, as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- Off-label drug use, except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription** drugs for the treatment of a dental condition unless dental benefits are provided under the policy.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **drug guide**.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member identified on the ID card.
- Replacement of lost or stolen **prescriptions**
- Tobacco cessation drugs, unless recommended by the United States Preventive Services Task Force (USPSTF)
- Test agents except diabetic test agents
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the policy's **drug guide**.

- Any dosage or form of a drug when the same drug is available in a different dosage or form on the policy's **drug guide**.

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 policy. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

Counseling services

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

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet

  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** 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 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
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. 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
    - A single baseline mammogram if you are age 35-39
    - Once per plan year if you are age 40 and older
- Prostate specific antigen (PSA) tests
- 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 (USPSTF).
- 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 including PrEP related services
    - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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
- Wigs and hairpieces for alopecia as a result of chemotherapy, radiation therapy, and second-or third-degree burns
- Orthopedic shoes and therapeutic shoes, only if the orthopedic shoe is an integral part of the covered leg brace.

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
- 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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop 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**

Spinal manipulation

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. You do not need a referral for **covered services** from a **network** chiropractic **provider**.

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** or
    - Help you maintain or prevent loss of physical function
- 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**

Telemedicine

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

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

The following are not **covered services**:

- 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 radiological services (X-ray)

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**. Inpatient **hospital** services are services provided for an evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in another participating health care facility which includes chemotherapy.

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **covered services** include:

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

Facilities/providers for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for **Banner|Aetna** and CVS Health.

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

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.

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

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

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

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

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

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

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

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

This includes the following transplant types, (others may also be eligible under your plan):

- 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 Individual Exchange-Institutes of Excellence™ (Exchange IOE) facilities in your **provider** directory.

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

Important note:
If there are no Exchange 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.

Travel and lodging expenses

Eligible health services include travel and lodging expenses for you and your companion to travel between your home and the **IOE facility** such as:

- Coach class round-trip air
- Train
- Bus travel
- Car travel, including a rental while at the transplant site. We will reimburse 37.5 cents per mile for personal vehicle use when the transplant site is more than 60 miles one way from the member's home.
- Lodging costs
- Food

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

- Evaluation
- Candidacy
- Transplant
- Post-transplant care

Travel expenses are limited to $10,000 per transplant procedure or type

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 at an urgent care center as described below:

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

If you go to an urgent care center for what is not an urgent condition, the plan will not cover your expenses.

Vision care

Pediatric vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction, glaucoma testing
- Eyeglass frames, **prescription** lenses or contact lenses

The following are not **covered services**:

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

Walk-in clinic

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

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

General policy exclusions

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

Behavioral health treatment

Services for the following based on categories, conditions, or 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
- Education service, special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with 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 Counseling services* and *Tobacco cessation prescription and OTC drugs* sections

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

Examples of these are:

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

Cosmetic services and plastic surgery

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

Court-ordered testing

Court-ordered testing or care unless **medically necessary**

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

Dental care

- Alveolectomy
- Apicoectomy (dental root resection)
- Augmentation and vestibuloplasty treatment of periodontal disease
- Cutting into gums and tissues of the mouth only when not associated with the removal, replacement, or repair of teeth
- Cutting out:
  - Teeth partly or completely impacted in the bone of the jaw
  - Teeth that will not erupt through the gum
  - Other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
  - Cysts, tumors, or other diseased tissues
- Dental implants
- Dental services related to the gums
- False teeth
- Orthodontics
- Root canal treatment
- Removal of soft tissue impactions
- Teeth - care, filling, removal, or replacement, including treatment of disease

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Services and supplies for:

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

Growth/height care

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

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: (except for medical supplies related to diabetes)
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Other 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 policy

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

Outpatient private duty nursing

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

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, except when used for physical therapy treatment
- 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
- Medications, except as specifically provided in the *Coverage and exclusions* section
- 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

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing
- Vision care services and supplies

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

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 policy works

How your policy works while you are covered

Your HMO policy helps you get and pay for a lot of - but not all - health care services. The policy usually pays only when you get care from **network providers**.

Providers

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

You choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care.

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

Service area

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

Who provides the care

Network providers

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

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 the 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 this policy owes.

Your PCP

To receive the network level of benefits, you must get **covered services** through your **PCP's** office. Your **PCP** will provide you with primary care.

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

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

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

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

If you do not select a PCP
Because having a **PCP** is so important, we may choose one for you. You will get an ID card in the mail. We will tell you the name, address and telephone number of your **PCP**. If you wish, you can change the **PCP** by following the directions above for *Changing your PCP*.

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

Keeping a provider you go to now (continuity of care)
You may have to find a new **provider** when:

- You join the policy and the **provider** you have now is not in the network
- You are already a **Banner|Aetna** member and your **provider** stops being in our network

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

If this situation applies to you, contact us for details. As long as the **provider** did not leave the network based on fraud, lack of quality standards, or our termination of the **provider**, you'll be able to receive transitional care from your **provide**r for a period up to 90 days from when we notified you of their network status or the end of your treatment, whichever is sooner.

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

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Medical necessity and precertification requirements
Your policy pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The service is **medically necessary**
- You get 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**.

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

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 policies. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

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

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

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

Requesting a medical exception

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

- Contact member services using the number on the back of your Banner|Aetna ID card
- Go online at https://www.banneraetna.com

- Submit the request in writing to:
  CVS Health
  ATTN: Banner|Aetna PA
  1300 E Campbell Road
  Richardson, TX 75081

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

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

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

What the policy pays and what you pay

Who pays for your **covered services** – this policy, 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 policy and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the policy 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 billing, 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 policy.

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

Surprise bill

There may be times when you unknowingly receive services or do not 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 then 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** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider**
- Non-emergency surgical or ancillary 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**
  - Obtaining consent from you to be treated and balance-billed by the **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.
Your protection from balance billing cannot be waived when:

- There is no in-network provider available
- For urgent or unforeseen care
- Ancillary services

Surgical or ancillary services mean any professional services including:

- **Surgery**
- Anesthesiology
- Pathology
- Radiology

- Hospitalist services
- Laboratory services

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
- 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:

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

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

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

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

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

Paying for covered services – the general requirements

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

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

Generally, your policy and you share the cost for **covered services** when you meet the general requirements. But sometimes your policy 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 policy requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care from **an out-of-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 policy. It also shows any **maximum out-of-pocket limits** that apply.

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

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

Coordination of benefits

This policy does not coordinate benefits with any other policies, except for any Medicare coverage or plan you may have. Please see the *If you become eligible for Medicare section of General provisions – other things you should know* for more information.

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 policy 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**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

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.

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

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

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. See *How to contact us for help*. For complaints about things handled by the Marketplace, such as enrollment, you can call or write the Marketplace to complain. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

The appeal process information packet explains all of your appeal rights. We sent you a copy of this. If you need another copy you can obtain one by calling us. See *How to contact us for help*. When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

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 policy 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 internal appeal. But in most situations you must complete before you can take any other actions, such as an external review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 72 hours for an urgent appeal and within 30 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

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

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 60 days for a post-service claim.

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

At your appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Exhaustion of appeal process

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

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

Sometimes you do not have to complete an appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Arizona or 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 Banner|Aetna. This is called an independent review organization (IRO).

You have a right to external review only if all the following conditions are met:

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

You may also request external review if you are seeking to determine 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.

IRO Decisions

The IRO will make a decision and notify the Insurance Director. The Insurance Director will notify us, you and your provider

You must submit the request for external review form:

- To Arizona Department of Insurance
- Within 4 months of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

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

The Insurance Director will contact the IRO that will conduct the review of your claim.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have 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 IRO makes, unless we can show conflict of interest, bias or fraud.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must call us or send us a request for external review form.

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

For initial adverse benefit determinations

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

For final adverse determinations

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

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

Utilization review

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

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

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.

Eligibility, starting and stopping coverage

The eligibility process and enrollment process are subject to any rules or other standards of the Marketplace and/or the Federal Department of Health and Human Services and state laws.

You will find information in this section about:

- Who can be on your policy (who can be your dependent)
- Special or limited enrollment periods
- Adding new dependents
- Effective date of coverage for your dependent

You are enrolled as the policyholder after you complete the eligibility and enrollment process with the Marketplace. You must pay the initial premium for your coverage to be effective. Your effective date of coverage is determined by the Marketplace.

Who can be a dependent on your policy

You can enroll the following family members on your policy. They are your "dependents":

- Your legal spouse
- Your domestic partner who meets eligibility requirements under applicable law.
- Your dependent children – your own or those of your spouse, domestic partner
  The children must be under 26 years of age and they include your:
  - Biological children
  - Stepchildren
  - Legally adopted children, including children placed with you for adoption
  - Foster children
  - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
  - Grandchildren in your court-ordered custody
  - Any children approved by the Marketplace

You can enroll your dependent:

- At initial enrollment
- At other special times during the year as listed below

A dependent must live in the state where the policy was issued and be approved by the Marketplace.

Adding new dependents

You can add the following new dependents to your policy:

- A spouse - If you marry, you can put your spouse on your policy:
  - The Marketplace must receive your completed enrollment information not more than 60 days after the date of your marriage
  - Coverage will be effective on the first day of the month following plan selection
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your policy:
  - The Marketplace must receive your completed enrollment information not more than 60 days after the date you file a Declaration of Domestic Partnership
  - Coverage will be effective on the first day of the month following plan selection

- A newborn child - Your newborn child is covered on your policy for the first 60 days after birth:
  - To keep your newborn covered, the Marketplace must receive your completed enrollment information within 60 days of birth
  - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional premium for the covered dependent
  - If you miss this deadline, your newborn will not have benefits after the first 60 days
- An adopted child – You may put an adopted child on your policy when the adoption is complete or the date the child is placed for adoption. "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child:
  - The Marketplace must receive your completed enrollment information within 60 days after the date of the adoption or the date the child was placed for adoption
  - Benefits for your adopted child will begin on the date of the adoption (or placement) or the first day of the month following adoption (or placement)
- A foster child – You may put a foster child on your policy when the child is placed in foster care. A foster child is a child whose care, comfort, education and upbringing is left to persons other than the natural parents:
  - The Marketplace must receive your completed enrollment information within 60 days after the date the child is placed with you.
  - Benefits for your foster child will begin on the date you legally become a foster parent or the first day of the month following this event.
- A stepchild - You may put a child of your spouse, domestic partner on your policy:
  - You must complete your enrollment information and send it to the Marketplace within 60 days after the date of your marriage, Declaration of Domestic Partnership with your stepchild's parent
- Court order – You can put a child you are responsible for under a qualified medical support order or court-order on your policy:
  - You must complete your enrollment information and send it to the Marketplace within 60 days after the date of the court order

Effective date of coverage for your dependent

Your dependent's coverage will start on your effective date of coverage, if you enrolled them at that time, otherwise:

- As shown above under the *Adding new dependents* section
- No later than the first day of the month following the date we receive your completed enrollment information
- In accordance with the effective date of a court order
- An appropriate date based on the circumstances of the special enrollment period

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

Special or limited enrollment periods

Federal law allows you and your dependents to enroll in a new policy under some circumstances. These are called special or limited enrollment periods. You can enroll in these situations when:

- You or your dependent have lost minimum essential coverage.
- You have added a dependent because of marriage, birth, adoption, placement for adoption, or placement in foster care. See the *Adding new dependents* section (below) for more information.
  - To qualify for a special enrollment period due to marriage, at least one spouse must be able to demonstrate they were enrolled in a plan with minimum essential coverage for at least one day in the 60 days before the date of marriage, or
    - lived in a foreign country or US territory at least one day in the 60 days before the date of marriage;
    - or is an American Indian or Alaskan Native.
- You or your dependent are enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement.
- You or your dependent's enrollment or non-enrollment in a plan through the Marketplace was not intended, was by accident or a mistake, and is because of an error, false information or delay by the Marketplace.
- You or your dependent have proven to the Marketplace that their plan did not honor or maintain an important provision of its contract with you or that you meet other unusual circumstances.
- You did not enroll a dependent in this policy before because they had other coverage and now that other coverage has ended.
- A court orders you to cover a current spouse, domestic partner or a child on your health policy.
- You or your dependent are newly eligible or not eligible for the premium tax credit or change in eligibility for cost share reduction, for Marketplace coverage.
- You or your dependent are eligible for new policies because you have moved to a new permanent location.
- You or your dependent are the victim of domestic abuse or spousal abandonment.
- You or your dependent become a citizen, a national or lawfully present in the United States.
- You are an American Indian or Alaska Native as defined by the Indian Health Care Improvement Act. In this situation:
  - You, or you and your dependents, can enroll in a qualified health plan (QHP) or change from one QHP to another.
  - You can do this one time per month.
- You or your dependent become eligible for state premium assistance under Medicaid or an S-CHIP plan for the payment of your premium contribution for coverage under this policy.
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan.
- You or your dependent are released from incarceration.
- You no longer receive employer contributions or government subsidies for COBRA coverage.

Regulatory changes may occur that impact and expand special enrollment periods which will apply to this policy. Please visit www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ for up-to-date information. The completed enrollment form may be submitted within 60 days of the event. However, if you did not receive notice of your triggering event, you will have 60 days from the time you are made aware of the event.

Notification of change in status

If there are any changes which will affect your policy or the eligibility of anyone covered under the policy, you must contact the Marketplace within 30 days of the date of the change. This may include changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- Change in health coverage through a job-based plan or program like Medicare, Medicaid or the Children's Health Insurance Program (CHIP) for you or your dependent

When coverage ends

When will your coverage end?

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

Your coverage under this policy will end if:

- This policy is discontinued
- You voluntarily stop your coverage by notifying the Marketplace in writing at least 14 days before the date you want your coverage to end
- You no longer meet the eligibility requirements of the Marketplace including moving out of the **service area**
- You do not pay the required premium payment by the end of the grace period
- This product is discontinued in the state, if approved by the insurance department of the state where this policy was issued
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this policy was issued
- We rescind your coverage, as permitted under this policy

When dependent coverage ends

Dependent coverage will end if:

- They no longer meets the eligibility requirements of the Marketplace
- The required premium contribution toward the cost of dependents' coverage is not made
- Your coverage ends for any of the reasons listed above

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

- The date this policy no longer allows coverage for domestic partners.
- The date the domestic partnership ends. For a domestic partnership, you should provide a completed and signed Declaration of Termination of Domestic Partnership to the Marketplace.

Notice of coverage ending

- The Marketplace will send you notice if your coverage is ending. This notice will tell you the date that coverage ends. Coverage will end immediately on the next premium contribution due date following the date on which you no longer meet the eligibility requirements.

When we would end coverage

We may immediately end your coverage if you commit fraud or intentionally misrepresent yourself when you applied for or got coverage. Please see the *General provisions – other things you should know* section for more information.

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

Special coverage options after your coverage ends

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

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

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

You have the right to extend coverage for your dependent **child** beyond the policy age limits if your disabled **child**:

- Is not able to be self-supporting because of mental or physical disability
- Depends mainly (more than 50% of income) on you for support

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

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

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this policy

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

How we administer this policy

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

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.

When you are no longer the policyholder

If you are no longer the policyholder, and the policy wasn't cancelled, your covered spouse, or domestic partner will become the policyholder. For a covered dependent child, the parent or legal guardian who is also covered under the policy will become the policyholder. If there is no policyholder at the end of a premium period, the policy will be cancelled.

Child-only coverage

In the case of child-only coverage, the parent or legal guardian in whose name the coverage under the policy is issued is considered the policyholder. As a parent or legal guardian, the policyholder has subscribed on behalf of the child for the benefits described in this policy. It is the policyholder's responsibility to make sure the child fulfills all terms and conditions outlined in this policy.

Coverage and services

Your coverage can change

Your coverage is defined by this policy. This document may have amendments or riders too. Under certain circumstances, we or an applicable law may change your policy. 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 policy. No other person, including your **provider**, can do this.

For any material modifications to your coverage, we will give you a 60 day notice

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

Intentional deception

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

- Rescission, which is loss of coverage going forward and backward
- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage:

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

Some other money issues

Assignment of benefits

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

Legal action

You must complete the internal appeal process 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.

Financial sanctions exclusions

If coverage provided under this policy 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 Assets Control (OFAC). You can find out more by visiting https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments

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

Effect of benefits under other policies

If you become eligible for Medicare

If you are eligible for Medicare Parts A, B or D, we will base our payment for **covered services** on the benefits covered by the Medicare part that you're eligible for. We will do this even if you are not enrolled in Medicare. Medicare will be the primary payor for the **covered services**.

If you have questions about Medicare, you can contact your local Social Security Administration office.

Workers' compensation

If benefits are paid by us and we determine you received worker's compensation benefits for the same event, we have the right to get back the payment we made ("recover") We will work to recover the money from you.

These recovery rights will be applied even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise
- No final determination is made that bodily injury or illness was sustained in the course of, or resulted from, your employment
- The amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier
- The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise

You agree that you will notify us of any workers' compensation claim you make, and that you will reimburse us as described above. If benefits are paid under this policy and you or any covered dependent recover payment or benefits from a responsible party, we have a right to recover from you or any covered dependent an amount equal to the amount we paid.

Non-duplication of benefits

If, while covered under this policy, you are covered by another Banner|Aetna individual coverage policy:

- You have a right only to benefits of the policy with the better benefits
- We will refund any premium charges you paid for the policy with the lesser benefits during the time you were covered by both plans

If, while covered under this policy, you are covered under a Banner|Aetna group plan:

- You have a right only to benefits of the group plan
- We will refund any premium charges you paid for the individual policy during the time you were covered by both plans

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 policy.

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

When you accept coverage under this policy, 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 properly licensed or certified to provide **covered services** for **mental health disorders** 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.

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

Copay, copayment
Copays are flat fees for certain visits. A **copay** can be a dollar amount or percentage.

Covered service
The benefits, subject to varying cost shares, covered under this policy. 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 policy exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your policy works – Medical necessity and precertification requirements* section and the *Glossary* for more information
- See Schedule of Benefits- *How your cost share works*

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

Dental provider
A **physician**, **health professional**, **dentist**, specialty **dentist**, person, or facility, licensed or certified by **applicable law** to provide you with dental care services.

Detoxification
The process of getting alcohol or other drugs out of a dependent person's system and getting them physically stable.

Drug guide
A list of **prescription** and over-the-counter (OTC) drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.banneraetna.com/en/pharmacy-resources.html. See *Contact us* section of the Policy.

Emergency medical condition

An acute, severe medical condition that:

- Needs immediate medical care
- Leads a person with 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.

Independent freestanding emergency department
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**.

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**, **coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

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

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

Generally accepted standards of medical practice means:

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

Mental health disorder

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

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). See page 47-48 of Policy for details.

Network provider

A **provider** listed in the directory for your policy.

Out-of-network provider

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

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

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

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

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

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

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 **substance related disorder** residential treatment programs:
  - A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
  - The medical director must be a **physician**
  - 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.

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.

Service area

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

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable 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.

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

Specialty prescription drugs
An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:
- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

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

Substance related disorder
A **substance related disorder**, addictive disorder, or both, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

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 electric communication.

Terminal illness
A medical prognosis that you are not likely to live more than 6-24 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 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, we designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, if you are a current member, contact the number on the back of your ID card.

If your 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 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 us 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, if you are a current member, contact the number on the back of your ID card.

Confidentiality Notice

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

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

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

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

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, **copayments**, or **coinsurance**, if any, that apply to the **covered services** you get under this plan. You should read this schedule to become aware of these and any limits that apply to the **covered services**. This schedule takes the place of any others sent to you before.

How your cost share works

- You are responsible to pay any **deductibles**, **copayments**, and remaining **coinsurance** if they apply.
- 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 or day limits.

Important note:
All **covered services** are subject to the calendar year **deductible**, **maximum out-of-pocket limit**, limits, **copayment**, or **coinsurance** unless otherwise noted in this schedule. The *Surprise bill* section of the policy explains your protection from a surprise bill.

Contact us

We are here to answer your questions. See the *Contact us* section of the policy.

Plan features

Deductible

You will continue to pay **copayments** or **coinsurance**, if any, for **covered services** after you meet your **deductible**.

Deductible	**Network**
Individual	$800 per year
Family	$1,600 per year

Individual deductible

You pay for **covered services** each year before the plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **covered services** for the rest of the year.

Family deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. To satisfy this family **deductible** for the rest of the year, the combined **covered services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a year. When this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Deductible credit
If you paid part or all of your **deductible** under other coverage for the year that this plan went into effect, we will deduct the amount paid under the other coverage from the **deductible** on this plan for the same year. If we ask, you must submit a detailed explanation of benefits (EOB) showing the dates and amount of the **deductible** met from the other coverage in order to receive the credit.

Maximum out-of-pocket limit

Maximum out-of-pocket limit	Network
Individual	$3,000 per year
Family	$6,000 per year

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

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:
All costs for any health care service you get that is not a **covered service**

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

Covered services
Your cost share for a **covered service** not listed with a specific cost share is based on the type of **covered service** you receive and where your **covered service** is received.

Acupuncture

Description	Network
Acupuncture	$20 no **deductible** applies
Visit limit per year	10

Allergy injections

Description	Network
Without a **physician** or **specialist** office visit	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services

Allergy testing and treatment

Description	Network
At a **physician** or **specialist** office	Cost share same as **PCP** or **specialist** office hours visit under **Physician** services

Ambulance service

Description	Network
Emergency ambulance	30% after **deductible**
Non-emergency ambulance	30% after **deductible**

Applied behavior analysis

Description	Network
Applied behavior analysis	30% after **deductible**

Autism spectrum disorder

Description	Network
Autism spectrum disorder	30% after **deductible**

Behavioral health

Mental health disorders and **substance related disorders** are covered under the same terms and conditions as any other illness.

Description	Network
Inpatient services	Cost share same as Inpatient services under **Hospital** care
Outpatient office visit to a **physician** or **behavioral health provider** (Includes **telemedicine** consultation)	$20 no **deductible** applies
Other outpatient services including behavioral health services in the home, partial hospitalization treatment, and intensive outpatient program The cost share does not apply to network peer counseling support services (Includes **telemedicine** consultation) after you meet your **deductible**, if you have one	30% after **deductible**

Durable medical equipment (DME)

Description	Network
DME	50% after **deductible**

Emergency services

A separate **hospital** emergency room cost share will apply for each visit to an emergency room.

Description	Network
Hospital emergency room	30% after **deductible**

Emergency services important note:
Out-of-network providers do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by you and the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill. If you are admitted to the **hospital** 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.

Habilitation therapy services

Description	Network
Physical, occupational, and speech therapies	30% after **deductible**

Hearing aids

Description	Network
Hearing aids	50% after **deductible**
Limit	Coverage is limited to 1 per ear per calendar year.

Hearing exams

Description	Network
Hearing exam	$40 no **deductible** applies
Limit per year	1

Home health care

Description	Network
Outpatient	30% after **deductible**
Visit limit per year	42

Home health care important note:
Limited to 3 intermittent visits per day provided by a **home health care agency**. 1 visit equals a period of 4 hours or less. Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge.

Hospice care

Description	Network
Inpatient services	30% after **deductible**
Outpatient services	30% after **deductible**

Hospital care

Description	Network
Inpatient services	30% after **deductible**

Jaw joint disorder

Description	Network
Jaw joint disorder treatment	Cost share based on type of service and where it is received

Maternity and related newborn care

Description	Network
Inpatient delivery services and postpartum care	30% after **deductible**
In a facility or at a **physician** office	30% after **deductible**

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

Medical injectables

Description	Network
Medical injectables	30% after **deductible**

Nutritional support

Description	Network
Nutritional support	25% no **deductible** applies

Obesity (bariatric) surgery

Description	Network
Obesity (bariatric) **surgery**	30% after **deductible**

Outpatient surgery

Description	Network
At a **hospital** outpatient department	30% after **deductible**
At a facility that is not a **hospital**	30% after **deductible**

Physician services

PCP

Description	Network
Office hours visit (not surgical and not preventive care) (includes **telemedicine** consultation)	$20 no **deductible** applies

Specialist

Description	Network
Office hours visit (not surgical) (includes **telemedicine** consultation)	$40 no **deductible** applies

Physician surgical services

Description	Network
Inpatient surgical services	30% after **deductible**
Outpatient surgical services	30% after **deductible**
Office surgical services	30% after **deductible**

Prescription drugs - outpatient

Tier 1 -- preferred and non-preferred generic prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$10 no **deductible** applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$25 no **deductible** applies

Tier 2 -- preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$20 no **deductible** applies
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$50 no **deductible** applies

Tier 3 -- non-preferred brand-name prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$60 after **deductible**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	$150 after **deductible**

Tier 4 -- specialty prescription drugs

Description	Network
For each 30 day supply filled at a **specialty pharmacy**	$250 after **deductible**

Anti-cancer prescription drugs taken by mouth

Description	Network
For each 30 day supply filled at a **specialty pharmacy**	$0 after **deductible**

Contraceptive (birth control)

Description	Network
For each 30 day supply of **generic prescription drugs** and OTC drugs and devices	$0 no **deductible** applies
For each 30 day supply of **brand-name prescription drugs** and devices	Paid according to the tier of drug above

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

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

Diabetic supplies, drugs, and insulin

Description	Network
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug above

Preventive care drugs and supplements and risk reducing breast cancer prescription drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy**	$0 no **deductible** applies
Limit	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered preventive care drugs and supplements and risk reducing cancer **prescription** drugs, see the *Contact us* section of the policy.

Tobacco cessation prescription and over-the-counter drugs

Description	Network
For each 30 day supply filled at a **retail pharmacy** Cost share only includes **generic prescription drugs** when there is also a brand-name drug available.	$0 no **deductible** applies for the first two 90-day treatment programs. Additional treatment programs will be paid according to the tier of drug above.
Limit	Subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation **prescription** drugs and OTC drugs, see the *Contact us* section of the policy.

Outpatient prescription drug important note:
If you or your **provider** requests a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the generic drug and the brand-name drug, plus the cost share that applies to the brand-name drug.

Preventive care

Description	Network
Preventive care	0% no **deductible** applies
Breast feeding counseling and support limit	6 visits per 12 months in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every year Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse visit limit	5 visits every 12 months
Counseling for risk for breast and ovarian cancer	Not subject to any age or frequency limitations
Counseling for obesity, healthy diet visit limit	Age 0-22: unlimited visits 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 visit limit	2 visits every 12 months
Counseling for tobacco cessation visit limit	8 visits every 12 months
Family planning services (female contraception and counseling) limit	Contraceptive counseling limited to 2 visits every 12 months in a group or individual setting
Immunization 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 For details, contact your **physician**
Prenatal care	See the *Preventive care, Prenatal care* section of the policy for more information

Description	Network
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: • Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF • The comprehensive guidelines supported by the Health Resources and Services Administration Lung cancer screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to: 7 exams from age 0-1 year 3 exams age 1-2 3 exams age 2-3 and 1 exam after that every 12 months High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older limited to 1 every 36 months
Well woman routine GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	Network
Prosthetic devices	50% after **deductible**

Short-term cardiac and pulmonary rehabilitation services

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

Description	Network
Cardiac and pulmonary rehabilitation	$20 no **deductible** applies

Short-term rehabilitation therapy services

A visit is equal to no more than 1 hour of therapy. Therapy visit limits (physical, occupational, and speech are combined, separate from habilitation

Outpatient physical therapy

Description	Network
Physical therapy	$20 no **deductible** applies
Visit limit per year	60

Outpatient occupational therapy

Description	Network
Occupational therapy	$20 no **deductible** applies
Visit limit per year	60

Outpatient speech therapy

Description	Network
Speech therapy	$20 no **deductible** applies
Visit limit per year	60

Spinal manipulation

Description	Network
Spinal manipulation	$20 no **deductible** applies
Visit limit per year	20 separate from habilitation and includes all outpatient places of service for spinal manipulation

Skilled nursing facility

Description	Network
Inpatient services	30% after **deductible**
Limit	Coverage is limited to 90 days per calendar year.

Telemedicine provider

Description	Network
PCP	$0 no **deductible** applies

Tests, images and lab – outpatient

Diagnostic complex imaging services

Description	Network
At a facility	30% after **deductible**
At a **physician** office	30% after **deductible**
At a **specialist** office	30% after **deductible**

Diagnostic lab work

Description	Designated network	Non-designated network
At a facility	0% no **deductible** applies	30% after **deductible**

Description	Network
At a **physician** office	30% after **deductible**
At a **specialist** office	30% after **deductible**

Diagnostic radiological services (X-ray)

Description	Network
At a facility	30% after **deductible**
At a **physician** office	30% after **deductible**
At a **specialist** office	30% after **deductible**

Therapies

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

Description	Network (GCIT-designated facility/provider)
Services and supplies	Cost share based on type of service and where it is received

Outpatient infusion therapy

Description	Network
In a **physician** office or in a person's home	$40 no **deductible** applies
In an outpatient facility	30% after **deductible**

Transplant services

Description	Network (Exchange IOE facility)	Out-of-network (Includes Aetna's **network providers** who are not Exchange IOE **providers**)
Services and supplies	30% after **deductible**	Not covered

Urgent care services

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

Description	Network
Urgent medical care at a freestanding facility that is not a **hospital**	$30 no **deductible** applies

Vision care

Pediatric vision care

Coverage is limited to covered persons through the end of the month in which the person turns 19.

Description	Network
Pediatric vision exam (including refraction)	50% after **deductible**
Visit limit per year	1

Vision care services and supplies

Description	Network
Eyeglass frames, **prescription** lenses or **prescription** contact lenses	50% after **deductible**

Limits

Description	Limit
Limited to one per year	One pair of eyeglasses (**prescription** lenses and frames) or One pair of regular contacts or Up to 3 month supply of daily wear disposable contact lenses or Up to 6 month supply of extended wear contact lenses

Vision care important note:
See the *Vision care* section of the policy for more information about vision services and supplies. This plan will cover either the purchase of **prescription** eyeglass lenses or contact lenses but not both. Coverage does not include the office visit for contact lenses fitting.

Voluntary sterilization

Description	Network
Vasectomy	Cost share based on type of service and where it is received

Walk-in clinic visits

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

Description	Designated network	Non-designated network
Non-emergency services	$0 no **deductible** applies	$20 no **deductible** applies
Telemedicine consultation for non-emergency services	0% no **deductible** applies	Cost share based on type of service and where it is received
Preventive care immunizations and preventive screening and counseling services (Includes **telemedicine** consultation) See the *Preventive care* section for more information	0% no **deductible** applies	0% no **deductible** applies