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Entering text into the form field will activate a list of options.

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The health guide

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- Managing health Managing health: Aetna health guide

More resources

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- Women's health
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Don’t have an account?

Sign up to find care, manage costs, try a health program and more. We’re with you on your journey.

Register

Already have an account? Log in

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Medicare

Going beyond Original Medicare with medical benefits, drug coverage and added benefits and services.

Go to Aetna Medicare

Affordable Care Act (ACA)

The quality Aetna® network of trusted local doctors plus the convenience of CVS® for individuals and families.

Go to Aetna CVS Health

Medicaid

Support and guidance for Medicaid members on their path to better health. We’re changing the way people get care.

Go to Aetna Better Health

Other sites for you

- Aetna International
- Aetna Student health

Vaccines and health screenings

Find helpful guidance to stay on top of the vaccines and screenings that are right for you.

Ready to make an appointment?

Find a provider

Preventive vaccine and screening benefitsThe power of prevention

What is preventive care?

Preventive care includes vaccines, well exams and routine screenings. Vaccines help protect you and others from harmful disease. Screenings check for medical issues early when they’re easier to treat. Together, it’s a powerful pair for overall health and wellness.

Does my health plan cover preventive care?

Most plans cover eligible preventive care services for $0 out of pocket. Check your plan documents to learn if your plan covers a service. You can also call us at the number on your member ID card.
Read More Read Less

Recommended vaccines and health screenings

We've gathered helpful info from trusted sources about vaccines and health screenings. Be sure to talk with your doctor about what may be right for you.

Vaccines help protect yourself and others

Vaccines help your immune system create antibodies that protect you from disease. With your Aetna® benefits plan, you're covered for a flu shot. Plus, non-seasonal vaccines, like RSV, pneumonia, shingles and Tdap. Check vaccine details.* We're bringing together what matters most to you.

Vaccines for children

Consider a vaccine schedule to help your kids stay protected.

Vaccines for adults

Learn what vaccines are recommended for you and your health.

Vaccine resources for Medicare members

No-cost flu shot

Protect yourself and those you love. It's easy to find a provider and schedule your flu shot visit.

Log in to find a network pharmacy or provider

Screening helps spot medical issues early

Looking for a simple way to check in on your health? Routine screenings check for diseases or conditions before there are signs or symptoms. This can help you get early treatment or even avoid a health issue.

Screenings by age

Find guidelines by age. We follow grade A and B recommendations.

Go to the U.S. Preventive Services Task Force

Screenings for women

Find preventive care guidelines for women's health and well-being.

Go to the Health Resources & Services Administration

Mental health screening

Find mental health screening and preventive care info.

Go to our mental health and well-being resources

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Health benefits and health insurance plans contain exclusions and limitations.

See all legal notices

For vaccine details

Flu shots and vaccines may not be available in all pharmacies at all times. Call for availability and to make an appointment, if needed. Most vaccines require a prescription (except for the flu shot).

The flu shot and many vaccines to treat common illnesses are generally covered under the Affordable Care Act by non-grandfathered group health plans and non-grandfathered individual and group health insurance coverage typically with no cost sharing if provided by an in-network provider, consistent with specified dosage limits and satisfaction of age and other vaccine specific requirements. Other restrictions may apply. Check with your health plan if you have any questions about your benefits.

Pharmacy benefits are administered by an affiliated pharmacy benefit manager, CVS Caremark®.

Also of interest:

-
-
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Helpful links

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About Aetna

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Guidance and support

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Rights and privacy

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- Health care reform

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- Vulnerability disclosure program

For language services, please call the number on your member ID card and request an operator. For other language services: Español-Spanish | 中文 | Tiếng Việt | 한국어 | Tagalog | Русский | العربية | Kreyòl | Français | Polski | Português | Italiano | Deutsch | 日本語 | فارسی | Other languages ...

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You are now being directed to the US Department of Health and Human Services site

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You are now being directed to The Fight Is In Us site

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Login

Please log in to your secure account to get what you need.

Continue

You are now leaving the Aetna Medicare website.

The information you will be accessing is provided by another organization or vendor. If you do not intend to leave our site, close this message.

Continue

Get a link to download the app

Just enter your mobile number and we'll text you a link to download the Aetna Health℠ app from the App Store or on Google Play.

Message and data rates may apply*

MOBILE NUMBER Please be sure to add a 1 before your mobile number, ex: 19876543210

This search uses the five-tier version of this plan

Each main plan type has more than one subtype. Some subtypes have five tiers of coverage. Others have four tiers, three tiers or two tiers. This search will use the five-tier subtype. It will show you whether a drug is covered or not covered, but the tier information may not be the same as it is for your specific plan. Do you want to continue?

back

Continue

Applied Behavior Analysis Medical Necessity Guide

By clicking on “I Accept”, I acknowledge and accept that:

The Applied Behavior Analysis (ABA) Medical Necessity Guide helps determine appropriate (medically necessary) levels and types of care for patients in need of evaluation and treatment for behavioral health conditions. The ABA Medical Necessity Guide does not constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any matters related to their coverage or condition with their treating provider.

Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary.

Please note also that the ABA Medical Necessity Guide may be updated and are, therefore, subject to change.

Medical necessity determinations in connection with coverage decisions are made on a case-by-case basis. In the event that a member disagrees with a coverage determination, member may be eligible for the right to an internal appeal and/or an independent external appeal in accordance with applicable federal or state law.

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You are now being directed to CVS Caremark® site.

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ASAM Terms and conditions

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I accept

Precertification lists

By clicking on “I accept”, I acknowledge and accept that:

Should the following terms and conditions be acceptable to you, please indicate your agreement and acceptance by selecting the button below labeled "I Accept".

- The term precertification here means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets the company's clinical criteria for coverage. It does not mean precertification as defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members.
- Applies to: Aetna Choice® POS, Aetna Choice POS II, Aetna Medicare℠ Plan (PPO), Aetna Medicare Plan (HMO), all Aetna HealthFund® products, Aetna Health Network Only℠, Aetna Health Network Option℠, Aetna Open Access® Elect Choice®, Aetna Open Access HMO, Aetna Open Access Managed Choice®, Open Access Aetna Select℠, Elect Choice, HMO, Managed Choice POS, Open Choice®, Quality Point-of-Service® (QPOS®), and Aetna Select℠ benefits plans and all products that may include the Aexcel®, Choose and Save℠, Aetna Performance Network or Savings Plus networks. Not all plans are offered in all service areas.
- All services deemed "never effective" are excluded from coverage. Aetna defines a service as "never effective" when it is not recognized according to professional standards of safety and effectiveness in the United States for diagnosis, care or treatment. Visit the secure website, available through www.aetna.com, for more information. Click on "Claims," "CPT/HCPCS Coding Tool," "Clinical Policy Code Search."
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- This information is neither an offer of coverage nor medical advice. It is only a partial, general description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan documents and this information, the plan documents will govern.

I accept

Dental clinical policy bulletins

By clicking on “I accept”, I acknowledge and accept that:

- Aetna Dental Clinical Policy Bulletins (DCPBs) are developed to assist in administering plan benefits and do not constitute dental advice. Treating providers are solely responsible for dental advice and treatment of members. Members should discuss any Dental Clinical Policy Bulletin (DCPB) related to their coverage or condition with their treating provider.
- While the Dental Clinical Policy Bulletins (DCPBs) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Dental Clinical Policy Bulletins (DCPBs) describe Aetna's current determinations of whether certain services or supplies are medically necessary, based upon a review of available clinical information. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. Aetna's conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna). Your benefits plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State or the Federal government.
- Please note also that Dental Clinical Policy Bulletins (DCPBs) are regularly updated and are therefore subject to change.
- Since Dental Clinical Policy Bulletins (DCPBs) can be highly technical and are designed to be used by our professional staff in making clinical determinations in connection with coverage decisions, members should review these Bulletins with their providers so they may fully understand our policies.
- Under certain plans, if more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that certain terms are met.

I accept

Medical clinical policy bulletins

By clicking on “I accept”, I acknowledge and accept that:

Should the following terms and conditions be acceptable to you, please indicate your agreement and acceptance by selecting the button below labeled "I Accept".

- Aetna Clinical Policy Bulletins (CPBs) are developed to assist in administering plan benefits and do not constitute medical advice. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any Clinical Policy Bulletin (CPB) related to their coverage or condition with their treating provider.
- While the Clinical Policy Bulletins (CPBs) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Policy Bulletins (CPBs) express Aetna's determination of whether certain services or supplies are medically necessary, experimental, investigational, unproven, or cosmetic. Aetna has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-

reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors).

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- CPBs include references to standard HIPAA compliant code sets to assist with search functions and to facilitate billing and payment for covered services. New and revised codes are added to the CPBs as they are updated. When billing, you must use the most appropriate code as of the effective date of the submission. Unlisted, unspecified and nonspecific codes should be avoided.
- Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Aetna) for a particular member. The member's benefit plan determines coverage. Some plans exclude coverage for services or supplies that Aetna considers medically necessary. If there is a discrepancy between a Clinical Policy Bulletin (CPB) and a member's plan of benefits, the benefits plan will govern.
- In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members.

See CMS's Medicare Coverage Center

- Please note also that Clinical Policy Bulletins (CPBs) are regularly updated and are therefore subject to change.
- Since Clinical Policy Bulletins (CPBs) can be highly technical and are designed to be used by our professional staff in making clinical determinations in connection with coverage decisions, members should review these Bulletins with their providers so they may fully understand our policies. Under certain circumstances, your physician may request a peer to peer review if they have a question or wish to discuss a medical necessity precertification determination made by our medical director in accordance with Aetna’s Clinical Policy Bulletin.
- While Clinical Policy Bulletins (CPBs) define Aetna's clinical policy, medical necessity determinations in connection with coverage decisions are made on a case by case basis. In the event that a member disagrees with a coverage determination, Aetna provides its members with the right to appeal the decision. In addition, a member may have an opportunity for an independent external review of coverage denials based on medical necessity or regarding the experimental and investigational status when the service or supply in question for which the member is financially responsible is $500 or greater. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans.

See Aetna's External Review Program

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Proceed to Healthcare.gov site

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