Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the employer for additional information.

Prepared for:

Employer:	The Dow Chemical Company
Contract number:	ASA-0607490
Control number:	0109190
Plan name:	Choice POS II Low Deductible Medical Plans AA-AI
Schedule of benefits:	3A
Plan effective date:	January 1, 2025
Plan issue date:	January 20, 2025

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a designated **network**, **non-designated network** or **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

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

How your maximum out-of-pocket works

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

Contact us

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

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

Plan features

Precertification covered services reduction

This only applies to non-designated and out-of-network **covered services**:

Your booklet contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A 20% **payment percentage** reduction applied separately to the benefit provided for each **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	The Dow Family Health Center network	Aetna network	Out-of-network
Individual Plan			
Employee only	Not applicable	$125 per year	$500 per year
Family Plan			
Individual	Not applicable	$250 per year	$1,000 per year
Family	Not applicable	$375 per year	$1,500 per year

Common Accident Deductible			
Common Accident **deductible**	Not applicable	$125 per admission	$500

Per admission copayment

Per admission copayment type	The Dow Family Health Center network	Aetna network	Out-of-network
Per admission copayment	Not applicable	$250 per admission	Not applicable
Per admission copayment Limit per family	Not applicable	$500 per admission	Not applicable

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	The Dow Family Health Center network	Aetna network	Out-of-network
Individual Plan			
Employee only	4% of annual salary $9,200 maximum per year	4% of annual salary $9,200 maximum per year	8% of annual salary per year
Family Plan			
Individual	4% of annual salary $9,200 maximum per year	4% of annual salary $9,200 maximum per year	12% of annual salary per year
Family	8% of annual salary $18,400 maximum per year	8% of annual salary $18,400 maximum per year	12% of annual salary per year

General coverage provisions

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

Deductible provisions

Covered services apply to the designated network, non-designated network and out-of-network **deductibles**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services.**

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.

Copayment

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

Per admission copayment

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

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

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

Covered services apply to the designated network, and non-designated-network, and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

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

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:
- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

Limit provisions
Covered services will apply separately to the designated network, and non-designated network, and out-of-network limits.

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

Covered services

Abortion

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Abortion	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Acupuncture

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Acupuncture in lieu of anesthesia	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Ambulance services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Emergency services	Not applicable	85% per trip after **deductible**	85% per trip after **deductible**
Non-**emergency services** ground, air, or water ambulance	Not covered	Not covered	Not covered

Applied behavior analysis

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Applied behavior analysis	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Diagnosis and testing	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	Not applicable	85% per admission after **deductible**	70% per admission after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**			
Provider's office	Not applicable Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Outpatient Facility		85% per visit after **deductible**	70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider mental health disorders consultation	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**
Coverage provided is the same as for any other illness

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services-**room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	Not applicable	85% per admission after **deductible**	70% per admission after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider** Provider's office Outpatient Facility	 Not applicable Not applicable	 $20 then the plan pays 100% per visit, no **deductible** applies 85% per visit after **deductible**	 70% per visit after **deductible** 70% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider substance related disorders consultation	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Clinical trials

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Experimental or investigational therapies	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic education			
Diabetic education	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Maximum per year per person	$500	$500	$500

Durable medical equipment (DME)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
DME	$10 then the plan pays 100% per item, no **deductible** applies	85% per item after **deductible**	70% per item after **deductible**

Emergency services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Emergency room	Not applicable	$100 then the plan pays 85% per visit after **deductible**	Paid same as in-network

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Non-emergency care in a **hospital** emergency room	Not applicable	$100 then the plan pays 85% per visit after **deductible**	$100 then the plan pays 70% per visit after **deductible**

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

Foot orthotic devices

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Orthotic devices	Not applicable	85% per item after **deductible**	70% per item after **deductible**

Habilitation therapy services

Outpatient physical (PT) and occupational (OT) therapies

Description	The Dow Family Health Center network	Aetna network	Out-of-network
PT	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**
OT	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Outpatient speech therapy (ST)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
ST therapy	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Hearing aids

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Hearing aids	Not applicable	85% per item after **deductible**	85% per item after **deductible**
Limit per 36 months	Not applicable	$3,000	$3,000

Hearing exams

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Hearing exams	Not applicable	$50 then the plan pays 100% per item, no **deductible** applies	$50 then the plan pays 100% per item, no **deductible** applies
Visit limit	Not Applicable	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Home health care	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

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

Hospice care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	100% per admission, no **deductible** applies	100%, no **deductible** applies
Other inpatient services and supplies	Not applicable	100% per admission, no **deductible** applies	100%, no **deductible** applies

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Limit per lifetime	unlimited	unlimited	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	$250 then the plan pays 85% per admissionafter **deductible**	70% after **deductible**

Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	70% after **deductible**

Infertility services

Basic infertility

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Treatment of basic **infertility**	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limited infertility services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services performed at **infertility specialist** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services performed at ART **specialist** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Fertility preservation	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limits

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Fertility preservation with a cancer diagnosis	Not applicable	$15,000 lifetime maximum Combined for in-network and out-of-network benefits	$15,000 lifetime maximum Combined for in-network and out-of-network benefits
Combined maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries and artificial insemination cycles per lifetime	Not applicable	6	6
Maximum ART cycles per lifetime	Not applicable	3	3

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	$250 then the plan pays 85% per admission after **deductible**	Not Covered	Not Covered
Outpatient	85% per visit after **deductible**	Not Covered	Not Covered
Precertification may be required			

Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Institutes of Quality – Cardiac Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	100% per admission, no **deductible applies**	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Outpatient	85% per visit after **deductible**	85% per visit after **deductible**	70% per visit after **deductible**
Precertification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Institutes of Quality – Orthopedic Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	100% per admission, no **deductible applies**	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Outpatient	85% per visit after **deductible**	85% per visit after **deductible**	70% per visit after **deductible**
Precertification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Jaw joint disorder

Includes TMJ

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Jaw joint disorder treatment For non-surgical treatment of TMJ and	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

for TMJ Intra-oral devices			

Limit per year	Not applicable	$500	$500

Maternity and related newborn care

Includes complications

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	70% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
Other services and supplies	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Treatment of mouth, jaws and teeth	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	The Dow Family Health Center network	Aetna network	Out-of- network
At **hospital** outpatient department	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
At facility that is not a **hospital**	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
At the **physician** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	The Dow Family Health	Aetna network	Out-of-network

	Center network		
Physician office hours (not surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Physician surgical services	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
All other services	100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Physician visit during inpatient **stay**	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Physician telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider consultation Basic medical services	$10 then the plan pays 100% per visit, no **deductible** applies	Covered based on type of service and **provider** from which it is received	Not covered

Specialist

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Specialist office hours (not surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
Specialist surgical services	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**
All other services	100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Specialist telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	70% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider consultation **Specialist** services	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Confirmatory Consultations (Second Opinions)			
	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

All other services not shown above

Description	The Dow Family Health Center network	Aetna network	Out-of-network
All other services	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Preventive care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	Not applicable	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Not applicable	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months 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	Not applicable	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/ per year	5 visits/ per year	5 visits/per year
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/ per year	2 visits/ per year	2 visits/per year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/per year	8 visits/per year	8 visits/per year
Family planning services	100% per visit, no	100% per visit, no	70% per visit after

(female contraception)	**deductible** applies	**deductible** applies	**deductible**
Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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**	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**
Generic preventive care contraceptives (birth control)	100%	100%	100%
Preventive care drugs and supplements	100%	100%	100%
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	100%	100%	100%
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Preventive care tobacco cessation **prescription** and OTC drugs	100%	100%	100%
Routine cancer screenings	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening from age 50 years	Not applicable	100%, no **deductible** applies	70% per visit, no **deductible** applies
Routine lung cancer screening limit from age 50 years	Not applicable	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100%, no **deductible** applies	100%, no **deductible** applies	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;

	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months
Well woman GYN exam	100%, no **deductible** applies	100%, no **deductible** applies	100% per visit, no **deductible** applies
Well woman GYN exam limit	1 visit per year	1 visit per year	1 visit per year

Private duty nursing

Up to 8 hours equals one shift

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
Visit/shift limit per year	Not applicable	120	120

Prosthetic devices

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Prosthetic devices	Not applicable	85% per item after **deductible**	70% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Surgery and supplies	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical therapy (PT)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**

Occupational therapy (OT)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Speech therapy (ST)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85%per visit after **deductible**	70% per visit after **deductible**

Spinal manipulation

Description	The Dow Family Health Center network	Aetna network	Out-of-network
At the **physician** office	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**
At the Lab	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	**Not covered**

Visit limit per year	30	30	30

Skilled nursing facility

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services – **room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	70% per admission after **deductible**
Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	70% per admission after **deductible**

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Diagnostic lab work

Description	The Dow Family Health Center network	Aetna network	Out-of- network
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	70% per visit after **deductible**

Therapies

Chemotherapy

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Chemotherapy services	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	85% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
In **physician** office	$10 then the plan pays 100% per visit after **deductible**	85% per visit after **deductible**	70% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
At **hospital** outpatient department	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**
At facility that is not a **hospital**	Not applicable	85% per visit after **deductible**	70% per visit after **deductible**

Radiation therapy

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Radiation therapy	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Respiratory therapy	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	The Dow Family Health Center network (IOE facility)	Aetna network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	Not applicable	$250 then the plan pays 85% per transplant after **deductible**	70% per transplant after **deductible**
Physician services	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

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

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

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Urgent care facility	Not applicable	$20 then the plan pays 100% per visit after **deductible**	70% per visit after **deductible**

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	100% per visit no **deductible** applies	100% per visit, no **deductible** applies

Visit limit	Not applicable	1 visit every year	1 visit every year

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a The Dow Family Health Center network **physician**.

Description	The Dow Family Health Center network	Designated network (CVS Minute Clinic)	Aetna network	Out-of-network
Non-**emergency services**	Not applicable	100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies
Preventive care immunizations	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive care immunization limits	Not applicable	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive screening and counseling limits	Not applicable	See the *Preventive care services* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule

Description	The Dow Family Health Center network	Designated network (CVS Minute Clinic)	Aetna network	Out-of-network
Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	Not applicable	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered
Telemedicine consultation for preventive	Not applicable	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered

screening and counseling services through a **walk-in clinic**				

Important note:
Key terms
The Dow Family Health Center network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Aetna network provider
A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a The Dow Family Health Center network **walk-in clinic provider**. Aetna network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the employer for additional information.

Prepared for:	
Employer:	The Dow Chemical Company
Contract number:	ASA-0607490
Control number:	0109190
Plan name:	Choice POSII Passive Low Deductible Medical Plans BE-BM
Schedule of benefits:	3B
Plan effective date:	January 1, 2025
Plan issue date:	January 20, 2025

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **copayment** or **payment percentage** you pay when you get **covered services** from a designated **network**, **non-designated network** or **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

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

How your maximum out-of-pocket works

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

Contact us

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

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

Plan features

Precertification covered services reduction

This only applies to non-designated and out-of-network **covered services**:

Your booklet contains a complete description of the **precertification** process. You will find details in the *How your plan works - Medical necessity and precertification requirements* section.

If **precertification** for **covered services** isn't completed, when required, it results in the following benefit reduction:

- A 20% **payment percentage** reduction applied separately to the benefit provided for each **covered service**

You may have to pay an additional portion of the **recognized charge** because you didn't get **precertification**. This portion is not a **covered service** and doesn't apply to your **deductible** or **maximum out-of-pocket limit**, if you have one.

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	The Dow Family Health Center network	Aetna network	Out-of-network
Individual Plan			
Employee only	Not applicable	$250 per year	$250 per year
Family Plan			
Individual	Not applicable	$500 per yearr	$500 per year
Family	Not applicable	$750 per year	$750 per year

Common Accident Deductible			
Common Accident **deductible**	Not applicable	$250 per year	$250 per year

Per admission copayment

Per admission copayment type	The Dow Family Health Center network	Aetna network	Out-of-network
Per admission copayment	Not applicable	$250 per admission	Not applicable
Per admission copayment Limit per family	Not applicable	$500 per admission	Not applicable
Per admission **deductible**	Not applicable	Not applicable	$250 per admission

Per admission copayment type	The Dow Family Health Center network	Aetna network	Out-of-network
Per admission deductible Limit per family	Not applicable	Not applicable	$500 per admission

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	The Dow Family Health Center network	Aetna network	Out-of-network
Individual Plan			
Employee only	4% of annual salary $9,200 maximum per year	4% of annual salary $9,200 maximum per year	8% of annual salary per year
Family Plan			
Individual	4% of annual salary $9,200 maximum per year	4% of annual salary $9,200 maximum per year	12% of annual salary per year
Family	8% of annual salary $18,400 maximum per year	8% of annual salary $18,400 maximum per year	12% of annual salary per year

General coverage provisions

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

Deductible provisions

Covered services apply to the designated network, non-designated network and out-of-network **deductibles**.

The **deductible** may not apply to some **covered services**. You still pay the **copayment** or **payment percentage**, if any, for these **covered services.**

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.

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

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

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

Per admission cost share or deductible
A separate cost share or **deductible** may apply per facility. This is in addition to any other cost share or **deductible** applicable under this plan. It may apply to each **stay** or on a per day basis up to a per admission maximum amount. If you are in the same type of facility more than once, and your **stays** are separated by less than 10 days (regardless of cause), only one per admission cost share or **deductible** will apply. Not more than three per admission cost shares or **deductibles** will apply for a facility type during the year. **Covered services** applied to the per admission **deductible** can't be applied to any other **deductible** required under the plan. **Covered services** applied to the plan's other **deductible** will not apply to the per admission **deductible**.

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

Covered services apply to the designated network, and non-designated-network, and out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit
- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:
- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

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

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

- All costs for non-**covered services** which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**

Limit provisions

Covered services will apply separately to the designated network, and non-designated network, and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Covered services

Abortion

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Abortion	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Acupuncture

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Acupuncture in lieu of anesthesia	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Ambulance services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Emergency services	Not applicable	85% per trip after **deductible**	Paid same as designated network
Non-**emergency services** ground, air, or water ambulance	Not covered	Not covered	Not covered

Applied behavior analysis

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Applied behavior analysis	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Diagnosis and testing	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	$250 then the plan pays 85% per admission after **deductible**
Other inpatient services and supplies Other **residential treatment facility** services and supplies	Not applicable	85% per admission after **deductible**	85% per admission after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**			
Provider's office	Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
Outpatient Facility	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider mental health disorders consultation	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **mental health disorders** consultation by a **telemedicine provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services-**room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	$250 then the plan pays 85% per admission after **deductible**
Other inpatient services and supplies during a **hospital stay**	Not applicable	85% per admission after **deductible**	85% per admission after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**			
Provider's office	Not applicable	$20 then the plan pays 85% per visit, no **deductible** applies	85% per visit after **deductible**
Outpatient Facility	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	Not applicable	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider substance related disorders consultation	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered
Telemedicine cognitive therapy **substance related disorders** consultation by a **telemedicine provider**	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Clinical trials

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Experimental or investigational therapies	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Diabetic services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic equipment	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Diabetic self-care programs	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Diabetic education			
Diabetic education	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Maximum per year per person	$500	$500	$500

Durable medical equipment (DME)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
DME	$10 then the plan pays 100% per item, no **deductible** applies	85% per item after **deductible**	85% per item after **deductible**

Emergency services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Emergency room	Not applicable	$100 then the plan pays 85% per visit after **deductible**	Paid same as in-network

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Non-emergency care in a **hospital** emergency room	Not applicable	$100 then the plan pays 85% per visit after **deductible**	$100 then the plan pays 85% per visit after **deductible**

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

Foot orthotic devices

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Orthotic devices	Not applicable	85% per item after **deductible**	85% per item after **deductible**

Habilitation therapy services

Outpatient physical (PT) and occupational (OT) therapies

Description	The Dow Family Health Center network	Aetna network	Out-of-network
PT	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**
OT	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Outpatient speech therapy (ST)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
ST therapy	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Hearing aids

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Hearing aids	Not applicable	85% per item after **deductible**	85% per item after **deductible**
Limit per 36 months	Not applicable	$3,000	$3,000

Hearing exams

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Hearing exams	Not applicable	$50 then the plan pays 100% per item, no **deductible** applies	$50 then the plan pays 100% per item, no **deductible** applies
Visit limit	Not Applicable	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Home health care	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

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

Hospice care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	100% per admission, no **deductible** applies	100%, no **deductible** applies
Other inpatient services and supplies	Not applicable	100% per admission, no **deductible** applies	100%, no **deductible** applies

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Limit per lifetime	unlimited	unlimited	unlimited

Hospice important note:
This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	$250 then the plan pays 85% per admissionafter **deductible**	85% after **deductible**
Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	85% after **deductible**

Infertility services

Basic infertility

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Treatment of basic **infertility**	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limited infertility services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services performed at **infertility specialist** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Advanced reproductive technology (ART)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services performed at ART **specialist** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Services performed at a facility other than a **hospital** outpatient department	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Fertility preservation	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Limits

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Fertility preservation with a cancer diagnosis	Not applicable	$15,000 lifetime maximum Combined for in-network and out-of-network benefits	$15,000 lifetime maximum Combined for in-network and out-of-network benefits
Combined maximum number of ovulation induction cycles per lifetime while on medications to stimulate the ovaries and artificial insemination cycles per lifetime	Not applicable	6	6
Maximum ART cycles per lifetime	Not applicable	3	3

Institutes of Quality – Bariatric Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	$250 then the plan pays 85% per admission after **deductible**	Not Covered	Not Covered
Outpatient	85% per visit after **deductible**	Not Covered	Not Covered
Precertification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Institutes of Quality – Cardiac Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	100% per admission, no **deductible applies**	$250 then the plan pays 85% per admission after **deductible**	85% per admission after **deductible**
Outpatient	85% per visit after **deductible**	85% per visit after **deductible**	85% per visit after **deductible**
Precertification may be required			
Physician services	Covered according to the	Covered according to the	Covered according to the

including office visits	type of benefit and the place where the service is received.	type of benefit and the place where the service is received.	type of benefit and the place where the service is received.

Institutes of Quality – Orthopedic Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	100% per admission, no **deductible applies**	$250 then the plan pays 85% per admission after **deductible**	85% per admission after **deductible**
Outpatient	85% per visit after **deductible**	85% per visit after **deductible**	85% per visit after **deductible**
Precertification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Jaw joint disorder

Includes TMJ

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Jaw joint disorder treatment For non-surgical treatment of TMJ and for TMJ Intra-oral devices	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Limit per year	Not applicable	$500	$500

Maternity and related newborn care

Includes complications

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services - **room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	$250 then the plan pays 85% per admission after **deductible**
Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	85% per admission after **deductible**

Services performed in **physician** or **specialist** office or a facility	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
Other services and supplies	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Treatment of mouth, jaws and teeth	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient surgery

Description	The Dow Family Health Center network	Aetna network	Out-of- network
At **hospital** outpatient department	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
At facility that is not a **hospital**	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
At the **physician** office	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Including surgical services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Physician office hours (not surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
Physician surgical services	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
All other services	100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Physician visit during inpatient **stay**	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Physician telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider consultation Basic medical services	$10 then the plan pays 100% per visit, no **deductible** applies	Covered based on type of service and **provider** from which it is received	Not covered

Specialist

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Specialist office hours (not surgical, not preventive)	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
Specialist surgical services	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**
All other services	100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Specialist telemedicine consultation	$10 then the plan pays 100% per visit, no **deductible** applies	$50 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Telemedicine provider consultation **Specialist** services	Not applicable	Covered based on type of service and **provider** from which it is received	Not covered

Confirmatory Consultations (Second Opinions)			
	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

All other services not shown above

Description	The Dow Family Health Center network	Aetna network	Out-of-network
All other services	Not applicable	85% per visit after	85% per visit after

		deductible	**deductible**

Preventive care

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Breast feeding counseling and support limit	Not applicable	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Not applicable	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months 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	Not applicable	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for alcohol or drug misuse visit limit	5 visits/ per year	5 visits/ per year	5 visits/per year
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for sexually transmitted infection visit limit	2 visits/ per year	2 visits/ per year	2 visits/per year
Counseling for tobacco cessation	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Counseling for tobacco cessation visit limit	8 visits/per year	8 visits/per year	8 visits/per year
Family planning services	100% per visit, no	100% per visit, no	85% per visit after

(female contraception)	**deductible** applies	**deductible** applies	**deductible**
Family planning services (female contraception) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no **deductible** applies	100%, no **deductible** applies	100%, no **deductible** applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	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**	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**
Generic preventive care contraceptives (birth control)	100%	100%	100%
Preventive care drugs and supplements	100%	100%	100%
Preventive care drugs and supplements limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section
Preventive care risk reducing breast cancer **prescription** drugs	100%	100%	100%
Preventive care risk reducing breast cancer **prescription** drugs limit	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the USPSTF For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section

Preventive care tobacco cessation **prescription** and OTC drugs	100%	100%	100%
Routine cancer screenings	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening from age 50 years	Not applicable	100%, no **deductible** applies	85% per visit, no **deductible** applies
Routine lung cancer screening limit from age 50 years	Not applicable	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100%, no **deductible** applies	100%, no **deductible** applies	100% per visit, no **deductible** applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2;

	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months	3 exams every 12 months age 2-3; and 1 exam every year thereafter High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1/36 months
Well woman GYN exam	100%, no **deductible** applies	100%, no **deductible** applies	100% per visit, no **deductible** applies
Well woman GYN exam limit	1 visit per year	1 visit per year	1 visit per year

Private duty nursing

Up to 8 hours equals one shift

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Outpatient services	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Visit/shift limit per year	Not applicable	120	120

Prosthetic devices

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Prosthetic devices	Not applicable	85% per item after **deductible**	85% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Surgery and supplies	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical therapy (PT)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**

Occupational therapy (OT)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Speech therapy (ST)

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85%per visit after **deductible**	85% per visit after **deductible**

Spinal manipulation

Description	The Dow Family Health Center network	Aetna network	Out-of-network
At the **physician** office	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**
At the Lab	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	**Not covered**

Visit limit per year	30	30	30

Skilled nursing facility

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Inpatient services – **room and board**	Not applicable	$250 then the plan pays 85% per admission after **deductible**	85% per admission after **deductible**
Other inpatient services and supplies	Not applicable	85% per admission after **deductible**	85% per admission after **deductible**

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Diagnostic lab work

Description	The Dow Family Health Center network	Aetna network	Out-of- network
	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies

Diagnostic x-ray and other radiological services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	$10 then the plan pays 100% per visit, no **deductible** applies	85% per visit after **deductible**	85% per visit after **deductible**

Therapies

Chemotherapy

Description	The Dow Family Health Center network	Aetna network	Out-of- network
Chemotherapy services	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

Description	In- network (GCIT-designated facility/provider)	Out-of-network (Including **providers** who are otherwise part of Aetna's network but are not GCIT-designated facilities/**providers**)
Services and supplies	Covered based on type of service and where it is received	Not covered
Gene therapy products, **prescription** drugs	85% after **deductible**	Not covered

Infusion therapy

Outpatient services

Description	The Dow Family Health Center network	Aetna network	Out-of-network
In **physician** office	$10 then the plan pays 100% per visit after **deductible**	85% per visit after **deductible**	85% per visit after **deductible**
At an infusion location	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
In the home	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
At **hospital** outpatient department	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**
At facility that is not a **hospital**	Not applicable	85% per visit after **deductible**	85% per visit after **deductible**

Radiation therapy

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Radiation therapy	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	The Dow Family Health Center network	Aetna network	Out-of-network
Respiratory therapy	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	The Dow Family Health Center network (IOE facility)	Aetna network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	Not applicable	$250 then the plan pays 85% per transplant after **deductible**	85% per transplant after **deductible**
Physician services	Not applicable	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

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

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

Description	The Dow Family Health	Aetna network	Out-of- network

	Center network		
Urgent care facility	Not applicable	$20 then the plan pays 100% per visit after **deductible**	$20 then the plan pays 100% per visit after **deductible**

Vision care

Performed by an ophthalmologist or optometrist and includes refraction

Description	The Dow Family Health Center network	Aetna network	Out-of-network
	Not applicable	100% per visit no **deductible** applies	100% per visit, no **deductible** applies

Visit limit	Not applicable	1 visit every year	1 visit every year

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a The Dow Family Health Center network **physician**.

Description	The Dow Family Health Center network	Designated network (CVS Minute Clinic)	Aetna network	Out-of-network
Non-**emergency services**	Not applicable	100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit, no **deductible** applies	$20 then the plan pays 100% per visit after **deductible**
Preventive care immunizations	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive care immunization limits	Not applicable	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Preventive screening and counseling services	Not applicable	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies	100% per visit, no **deductible** applies
Preventive screening and counseling limits	Not applicable	See the *Preventive care services* section of the schedule	See the *Preventive care* section of the schedule	See the *Preventive care* section of the schedule

Description	The Dow Family Health Center network	Designated network (CVS Minute Clinic)	Aetna network	Out-of-network
Telemedicine consultation for non-**emergency services** through a **walk-in clinic**	Not applicable	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered
Telemedicine consultation for preventive screening and counseling services through a **walk-in clinic**	Not applicable	100% per visit, no **deductible** applies	Covered based on type of service and where it is received	Not covered

Important note:
Key terms
Designated network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.
See the *Contact us* section if you have questions.

You will pay less cost share when you use a designated network **walk-in clinic provider**. Non-designated network **walk-in clinic providers** are available to you, but the cost share will be at a higher level when these **providers** are used.

Choice POS II medical plan

Booklet

Prepared for:

Employer:	The Dow Chemical Company
Contract number:	ASA-0607490
Control number:	0109190
Plan name:	Choice POS II Low Deductible Medical Plans AA-AI, BE-BM
Booklet:	3
Plan effective date:	January 1, 2025
Plan issue date:	January 20, 2025

Third Party Administrative Services provided by
Aetna Life Insurance Company

Table of contents

Welcome

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

Welcome to Aetna.

Introduction

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

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

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

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

How we use words

When we use:

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

Contact us

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

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

- Calling the toll-free number on your ID card
- Writing us at 151 Farmington Ave, Hartford, CT, 06156
- Visiting https://www.aetna.com to 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

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

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 an 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 **payment percentage** 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.

Coverage and exclusions

Providing covered services

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

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

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

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.

- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.

- Your **provider** may recommend services that are considered **experimental**, **investigational**, or unproven services. But an **experimental**, **investigational**, or unproven service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.

- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

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

Abortion

Covered services include the following services provided by your **physician**:

- Abortion, including abortion drugs dispensed by a provider (including a telemedicine provider), where permitted by state and local laws.

Acupuncture

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

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

Ambulance services

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

Emergency

Covered services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide **emergency services**
- From one facility to another if the first can't provide the **emergency services** you need

Non-emergency

Covered services also include non-emergency transportation when an ambulance is the only safe way to transport you. These non-emergency ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not **covered services**:

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

Applied behavior analysis

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

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

Autism spectrum disorder

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

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

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

Behavioral health

Mental health treatment

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

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

Substance related disorders treatment

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

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

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

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

Clinical trials

Routine patient costs

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

The following are not **covered services**:

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

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 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
- Equipment
  - External insulin pumps and pump supplies
  - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training

Durable medical equipment (DME)

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

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

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

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

Covered services also include:

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

The following are not **covered services**:

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

- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

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

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

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

If 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 plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician** (**PCP**).

Non-emergency services

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

Foot orthotic devices

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

Gender affirming treatment

Covered services include certain services and supplies for gender affirming treatment.

Please call Member Services for more information at the number on the back of your ID Card.

Below is an expanded list of gender affirming surgeries and procedures covered under your medical plan that are subject to a $100,000 lifetime maximum:

First Criteria:	You must have one of the 5 diagnoses listed below in order to be covered for the enhanced cosmetic procedures listed below.
	Transexualism and dual role transvestism
	Gender identity disorder of childhood
	Other gender identity disorders
	Gender identity disorder, unspecified
	Personal history of sex reassignment

Cosmetic Procedures:	
Hair Removal and Transplant	Laser
	Electrolysis
	Hair Transplant Punch Graft
Facial Reconstruction/Contouring	Excision Excessive Skin - Other Area
	Thyroid Chondroplasty and Tracheal Shave
	Hairline Advancement
	Blepharoplasty/ptosis
	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (including obtaining autografts) (eg microophthalmia)
	Malar (cheek) Implants
	Rhytidectomy - Face Lift
	Jaw and/or Chin Re-shaping
	Lip Shortening
	Scalp (hairline) Advancement / Forehead Contouring
	Rhinoplasty & Graft codes
	Chin Implant and/or Genioplasty
	Jaw Implant
	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)
	Steorotactic computer-assisted procedure; Crainial
	Reconstruction midface
	Reconstruction orbital rim and lower forehead
	Reduction of masseter muscle and bone
	Repair, complex, forehead, cheeks, chin, mouth, neck
	Adjacent tissue transfer
Voice	Voice Therapy - 30 visits (additional visits approved based on medical necessity)
	Voice Modification Surgery
Body Contouring	Tissue grafts, other (EG, paratenon, fat, dermis, etc)/Tissue transfer
	Flap
	Tissue expander other than breast
	Suction assisted lipectomy - head and neck
	Suction assisted lipectomy - trunk
	Suction assisted lipectomy - upper extremity
	Suction assisted lipectomy - lower extremity
	Subcutaneous injection of filling material

	Adjacent tissue transfer or rearrangement
	Excision, Excessive Skin and Subcutaneous tissue (Includes lipectomy)

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

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapies

Covered services include:

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

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

The following are not **covered services**:

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

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
- 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

- Batteries or cords
- 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 *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

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

Hospice care

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

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

- Pain management and symptom control
- Bereavement counseling
- Respite care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription** drugs
  - Psychological counseling
  - Dietary counseling

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood products

The following are not **covered services**:

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

Infertility services

Basic infertility

Covered services include seeing a **provider**:

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

Limited infertility services

Covered services include the following **infertility** services provided by an **infertility specialist**:

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.
- **Prescription** drugs injected by your **provider** to stimulate the ovaries.

Advanced reproductive technology (ART)

Advanced reproductive technology**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment.

Covered services include the following services provided by an ART **specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Cryopreservation (freezing) of eggs, embryos, or sperm including 12 months of storage.
- Thawing of cryopreserved (frozen) eggs or sperm.
-
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

Prescription drugs injected by your **provider** to stimulate the ovaries.

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan.

For plans with ovulation induction cycle limits, an ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

For plans with ART cycle limits, an ART "cycle" is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Aetna's National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can

also give you information about our infertility Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your infertility services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation
Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use including 12 months of storage.

Covered services for fertility preservation are provided when:

You have planned medical services that are proven to result in **infertility** such as:

- Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
- Other gonadotoxic therapies
- Removing the uterus
- Removing both ovaries or testicles

- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy

Premature ovarian insufficiency
If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Infertility services exclusions:

The following are not **covered services**:

- Cryopreservation (freezing) and storage of reproductive tissue.
- Thawing of cryopreserved (frozen) reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
    - Infertility medication not injected by your **provider**, including but not limited to menotropins, hCG, and GnRH agonists. See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs for your plan.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
    - The purchase of donor embryos, donor eggs or donor sperm.
    - Obtaining sperm from a person not covered under this plan.
        - **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
        - **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
        - **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH

level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.

Treatment for dependent children, except for fertility preservation as described above.

Institutes of Quality

Aetna Institutes of Quality (IOQ) program is a network of facilities/clinics of publicly recognized, high-quality, high-value health care providers. These providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as cost-effectiveness criteria. The Institutes of Quality program applies to adult members (age 18 and over) only.

The IOQs are Aetna facilities participating under standard Aetna contracts and are *designated* through a targeted Request For Information (RFI) process. Designation is valid for two years provided that the facility maintains compliance with the IOQ program requirements.

Institutes of Quality Bariatric

Bariatric surgery, also known as weight loss surgery, refers to the various surgical procedures performed to treat people living with morbid or extreme obesity. It is an effective treatment for weight loss for those who have not experienced long-term weight loss success through other means.

Bariatric IOQ facilities provide the following services:

- Lap bands - device wrapped around upper part of stomach to make it smaller for less food intake
- Bypass - creation of a small pouch in stomach that is connected pouch directly to middle part of small intestine, bypassing the remainder of stomach and upper small intestine
- Sleeve gastrectomy - removal of majority of stomach creating narrow tube to decrease amount of food eaten and decrease amount of food absorbed

Institutes of Quality Cardiac Care

Institutes of Quality Cardiac Care facilities is a network of providers that have met Aetna's requirements for clinical quality, value and access for cardiac care. Aetna worked with heart experts and professional groups to create our quality network requirements. These groups include the American College of Cardiology (ACC) and the Society for Thoracic Surgeons (STS).

Cardiac IOQ facilities provide the following services:

- Surgery
    - CABG, Valve w/ CABG, Valve w/out CABG - repairing or replacing the damaged flaps inside the heart to allow blood to flow more easily and in the right direction

Institutes of Quality Orthopedic Care

Institutes of Quality Orthopedic Care is a network of providers that have met Aetna's requirements for clinical quality, value and access for orthopedic care. The procedure evaluation is limited to knee replacement, hip replacement, and spine surgery. Facilities must meet all requirements for knee and hip replacement to be designated for either, while spine surgery designation may be a stand-alone designation. A facility may also be designated for all three disciplines if all program requirements are met.

Aetna Orthopedic IOQs provide a full range of orthopedic care services. These include:

- Spine
    - Primary Fusion - surgery to join or fuse two or more vertebrae together
    - Fusion Revision - surgery done when the first operation to fuse the vertebrae does not work
    - Discectomy (w/out decompression) - removal of protruding disc material that is pressing on a nerve or the spinal cord

    - Decompression (w/out fusion) - removal of bony growths or parts of vertebrae to enlarge spinal canal to relieve pressure on nerve roots
- Total Joint Replacement
    - Knee Replacement - replacement of both damaged bone ends of the joint and knee cap with artificial material
    - Hip Replacement - replacement of the damaged joint with an implant

Jaw joint disorder treatment

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

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

Maternity and related newborn care

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

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

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- 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.
- Cutting into gums and tissues of the mouth
    - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

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

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

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- Services of another **physician** for the administration of a local anesthetic

Physician services

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

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

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

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

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

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

Preventive care

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

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

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

Family planning services – female contraceptives

Covered services include family planning services as follows:

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

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

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- 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

Preventive care drugs

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 you **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception methods is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each of the methods identified by the FDA at no cost to you. If a **generic prescription drug** or device is not available for a certain method, you may obtain certain **brand-name prescription drugs** or devices for that method at no cost.

The following is not a **covered service**:
Brand-name prescription drug forms of contraception in each of the methods identified by the FDA

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

Preventive care drugs and supplements

Covered services include preventive care drugs and supplements, including OTC ones, as required by the ACA, when you have a **prescription** and it is filled at a network pharmacy.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at an increased risk for breast cancer and a low risk for adverse medication side effects. You will need a **prescription** from your **provider** and have it filled at a network pharmacy.

Tobacco cessation prescription drugs

Covered services include FDA-approved drugs and OTC aids and drugs to help stop the use of tobacco products, including nicotine replacement therapy. All OTC aids must be prescribed by a **provider**.

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

Routine physical exams

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

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

Covered services include:

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

Well woman preventive visits

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

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

Private duty nursing - outpatient

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

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care

- Periodic skilled nursing visits are not adequate

The following are not **covered services**:
- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

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

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

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

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

The following are not **covered services**:
- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies
Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies
Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part, and
  - 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.

Accidental injury to natural teeth

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 accident-related dental services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Covered services include:

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

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

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

Specialty prescription drugs

Covered services include **specialty prescription drugs** when they are:
Purchased by your **provider**
Injected or infused by your **provider** in an outpatient setting such as:
A freestanding outpatient facility
The outpatient department of a **hospital**
A **physician** in the office
A home care **provider** in your home

Telemedicine

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

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

The following are not **covered services**:

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

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

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

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

GCIT **covered services** include:

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

- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

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

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

The following are not **covered services** unless you receive prior written approval from us:
- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

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

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

Cellular
Relating to or consisting of living cells.

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

We call these "GCIT services".

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

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

Molecular
Relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest

vital unit of a chemical compound that can take part in a chemical reaction.

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

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

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

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

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

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

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

This includes the following transplant types:
- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need.

Transplant services received from an IOE facility are subject to the network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this booklet and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket**, and limits, unless stated differently in this booklet and schedule of benefits.

Important note:
If there are no IOE facilities assigned to perform your transplant type among the **designated network provider** facilities for your plan, 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, your cost share will be higher.

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

The following are not **covered services**:

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

Travel and Lodging

If the following **covered services** are not available from a **network provider** within 100 miles of your home, certain travel and lodging expenses are covered under the plan.

- **Abortion**
- **Gender Affirming Treatment**

The plan covers U.S. domestic travel and lodging expenses for you and one companion, to travel from your home to receive **Abortion** services (surgical or medication induced) from any provider and **Gender Affirming Treatment** (surgery and/or hormone-related medication) from a **network provider.** Coach class air fare, train or bus travel are examples of covered services.

- The maximum lodging benefit is $50 per person per night, up to a to total maximum lodging benefit of $100.
- Total maximum travel and lodging benefit is $10,000 per **occurrence.**

To be eligible for travel and lodging reimbursement, Aetna Member Services must first confirm a network provider is not available within 100 miles of your home and a travel and lodging claim form must be completed. To obtain this confirmation and the travel and lodging claim form, and for detailed information

about these covered services, including specific eligibility requirements and any limitations, contact Member Services at the toll-free number on your ID card. Receipt of prior confirmation from Member Services is not required to receive travel and lodging benefits for abortion services, however Member Services can still assist you with locating a provider.

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.

If you need care for an urgent condition, you should first seek care through your **physician, PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center.

Vision care

Covered services include:

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

The following are not **covered services**:

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

Walk-in clinic

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

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

General plan exclusions

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

Behavioral health treatment

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

- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

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

Blood, blood products, and related services which are supplied to your **provider** free of charge

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

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment**, **payment percentage**, **deductible**, or any other amount

Court-ordered services and supplies

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

Custodial care

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

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

- Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
- Services given mainly to:
    - Maintain, not improve, a level of function
        - Provide a place free from conditions that could make your physical or mental state worse

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

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

Foot care

Routine services and supplies for the following:

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

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

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

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

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

Growth/height care

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

Maintenance care

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

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins

- **Prescription** vitamins
- Medical foods
- Other nutritional items

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Prescription or non-prescription drugs and medicines – outpatient

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

Routine exams and preventive services and supplies

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

Services not permitted by law

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

Note that in some cases the plan may provide travel benefits for services affected by this exclusion. For detailed information about these excluded services, call the toll-free number on your ID card.

Services provided by a family member

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

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

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 plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of, but not all, health care services. Your cost share is lower when you use a **network provider**.

Providers

Our **designated** and **non-designated provider** network is there to give you the care you need. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. See the *Contact us* section for more information. .We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the network. See the Contact us section for more information.
Your cost share will be lower when you use a **designated network provider**. You may also get care from **non-designated network providers**, but your cost share will be higher.

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

You may not select a **non-designated network provider** as a **PCP** unless authorized by us with a special **referral**.

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

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

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network and from **network providers** without a **PCP referral**
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Your Dow Chemical medical plan will no longer pay for any services received at certain facilities.

These facilities are:

University General Hospital, LP

- Oprex Surgery Houston, LP
- Houston Microsurgery Institute
- International Center for Surgical Science
- First Street Hospital
- First Surgical Hospital
- Spars Surgical Center
- Houston Metro Ortho and Spine Surgery Center

- Kirby Surgical Center
- The Houston Center for Outpatient Surgery
- Physician's Surgicenter of Houston
- St. Michael's Center for Special Surgery
- Center for Minimally Invasive Surgery, LLC
- Bellaire Surgical Hospital (formerly 1st Surgical Hospital)
- Bellaire Surg Hosp

Altus Houston Hospital

- MVP Specialist Surgery Center
- Weslayan Surgical Center

This means that there is no coverage for both:

- health care services provided by these facilities, and
- health care services provided by physicians and other health care professionals at these facilities.

If you use any of these facilities for any service, you will be responsible for the full cost of services.

Who provides the care

Network providers

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

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

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

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

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

Your PCP

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

How you choose your PCP

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

What your PCP will do for you

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

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

Out-of-network providers
You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **recognized charge**
- Submitting your own claims and getting **precertification**

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

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

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

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

- The service is **medically necessary**
- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required

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

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

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

In-network

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

Out-of-network
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

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

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

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

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

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

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

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

Types of services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies.
Precertification is required for the following types of services and supplies:
Inpatient –

- Gender affirming treatment

- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **Stays** in a hospice facility
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**
- **Stays** in a **skilled nursing facility**

Outpatient –

- ART services
- Complex imaging
- Cosmetic and reconstructive **surgery**
- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Home health care
- Hospice care
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Limited infertility services
- Non-emergency transportation by airplane
- Obesity (bariatric) **surgery**
- Outpatient back **surgery** not performed in a **physician's** office
- Partial hospitalization treatment – **mental health disorders** and **substance related disorders** treatment
- Private duty nursing services
- Sleep studies
- Transcranial magnetic stimulation (TMS)
- Wrist **surgery**

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

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

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

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

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

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

Some **providers** are part of Aetna's **network** for some Aetna plans but are not considered **network providers** for your plan. For those **providers**, the **negotiated charge** is the amount that **provider** has agreed to accept for rendering services or providing **prescription** drugs to members of your plan.

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

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

Some of these arrangements are called:

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

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

Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You may be responsible for all amounts above what is eligible for coverage. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage (see *Surprise Bill* for more information).

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider** for whom we access NAP rates. Through NAP, the **recognized charge** is determined as follows:

- If your service was received from a NAP **provider**, a pre-negotiated charge **may** be paid**.** NAP **providers** are **out-of-network providers** that have contracts with Aetna, directly or through third-party vendors, that include a pre-**negotiated charge** for services. NAP **providers** are not **network providers**. (At times Aetna may choose to terminate specific providers from NAP and will notify the provider of such a decision).

- If your service was not received from a NAP **provider,** a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the **recognized charge** for specific services or supplies will be the **out-of-network plan rate**, calculated in accordance with the following:

Service or Supply:	**Out-of-Network Plan Rate**
Professional services and other services or supplies not mentioned below	An amount determined by Aetna, or its third-party vendors, based on data resources selected by Aetna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Services of **hospitals** and other facilities	Reasonable amount rate

Important note:
See *Special terms used* below, for a description of what the **recognized charge** is based on.
If the **provider** bills less than the amount calculated using a method above, the **recognized charge** is what the **provider** bills.

In the event you receive a balance bill from a **provider** for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances. If Patient Advocacy Services are available for your claim, additional information will be provided to you.

If NAP does not apply to you, the **recognized charge** for specific services or supplies will be the out-of-network plan rate set forth in the above chart.

The out-of-network plan rate does not apply to involuntary services. See *Surprise Bill* for more information.

Special terms used:

- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the **provider** with a reasonable profit. This means for:
  - **Hospitals** and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
  - Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

  We may adjust the formula as needed to maintain the reasonableness of the **recognized charge**. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Our reimbursement policies
We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **recognized charge**. When we do this, we consider:

- The length and difficulty of a service

- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

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

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

Surprise bill

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

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

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

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

Ancillary services mean any professional services including:

- Items and services related to emergency medicine

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

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

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

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

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

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

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

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

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

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

Paying for covered services – the general requirements

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

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

For **out-of-network** coverage:

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

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

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care and the **provider** waives all or part of your cost share.

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

When your Spouse/Domestic Partner is employed and is enrolled for medical coverage through his/her non-Dow-affiliated employer, benefit payments will be coordinated with your Dow Medical Plan. This means that Claims may be filed to collect from both plans.

For High Deductible, Low Deductible and Catastrophic Medical, the total benefits paid by Dow may not exceed the **Negotiated Charge** (for Services received through an In-Network Provider) or the **Recognized Charge** (for Services received through an Out-of-Network Provider or Out-of-Area).

Note: Dual coverage usually does NOT provide 100% coverage.

Primary versus Secondary Plans:
When two different group plans provide coverage for you and your Dependents, the primary plan pays benefits first. The plan that is secondary determines benefits available after payment by the primary plan. This chart shows how it works:

When the Patient is	Your Dow Plan will be	The other Group Plan will be
The Dow Employee:	Primary	Secondary*
A Non-Dow employed Spouse/Domestic Partner:	Secondary	Primary
A Dependent child, and the parent whose birthday falls **earlier** in the year is the Dow Employee:	Primary	Secondary*
A Dependent child, and the parent whose birthday falls **later** in the year is the Dow Employee:	Secondary	Primary
When you are covered by Dow COBRA and you have coverage through your current employer:	Secondary	Primary

*When the other group plan does not include a coordination of benefits provision, the other plan is always primary. Court rulings may supersede the order of benefits determination.

If you are in an automobile accident, your automobile insurance will be the primary plan for medical expenses resulting from treatment for injuries from the accident.

Note: When all Plans have a coordination of benefits provision and both parents have the same birth date, the Plan that insured the child the longest pays first.

Dow as the Secondary Plan:
The following rules apply when the Dow Medical Plan provides secondary coverage.

- Dow pays based on the balance remaining following payment by the primary plan, using all Dow benefits provisions.
- If payment by the primary plan is equal to or greater than either Dow's **Negotiated Charge** (if Services were received through an In-Network Provider) or the **Recognized Charge** (if Services were received through an Out-of-Network Provider or Out-of-Area), no benefits will be payable by the Dow Plan.
- Dow does not reimburse for expenses not covered by the Dow Medical Plan in which you are enrolled.
- If your Spouse's/Domestic Partner's non-Dow employer offers a choice of plans, the Dow Plan benefits will be coordinated with those of the plan that is most comparable to the Dow Medical Plan you are enrolled in, regardless of the non-Dow medical plan in which your Spouse/Domestic Partner is actually enrolled.
- If your Spouse's/Domestic Partner's plan is a Health Maintenance Organization (HMO), and a service normally provided by the HMO is received from a Provider not affiliated with the HMO, no benefits will be payable under the Dow Medical Plan.
- If you are covered under a Dow Medical Plan and your Spouse/Domestic Partner is covered under an HMO plan, and each of you cover the other, your Dow Medical Plan will not cover charges for Services performed on behalf of your Spouse/Domestic Partner that are, or would have been, eligible for coverage through your Spouse's/Domestic Partner's HMO.
- If your Spouse's/Domestic Partner's plan has special requirements, including but not limited to, mandatory second surgical opinions, use of Network Providers, Outpatient surgery for certain procedures, pre-certification of Hospital admissions, or pre-admission testing, the Dow Medical Plan will not cover any expenses resulting from failure to comply with these requirements.

Periodically, you may be requested to provide coordination of benefits information including, but not limited to, whether your Spouse/Domestic Partner works, details about the coverage available as a result of that employment, and specific coverage information. The Plan may withhold Plan benefits if you or your Dependents fail to produce the required information.

Medicare:
Here are guidelines for coordination of benefits when Medicare is involved:

- **If you are an active Employee and you and/or your Dependents are enrolled under Medicare** - the Dow Medical Plan will pay first, Medicare will be secondary.
- **If your Spouse/Domestic Partner is age 65 or older and is a full-time employee of another company -** he/she will have primary coverage through the other employer's plan.
- **If you Spouse/Domestic Partner is age 65 or older and is a retiree of another company and you are an active Employee -** the Dow Plan will be primary as it is the only active Plan. However, your Spouse/Domestic Partner should not cancel coverage under the other employer's plan unless he/she can get back into that plan when you retire.

Health Care Benefits through Automobile Insurance:
Sometimes an Employee or Dependent is entitled to health care benefits through automobile insurance. Should this type of duplication occur, the benefits under your Dow Medical Plans will be coordinated so that the total benefits from all Plans do not exceed the **Negotiated Charge** (for In-Network Services) or the **Recognized Charge** (for Out-of-Network and Out-of-Area Services). Your Dow Medical Plan will be secondary to the automobile insurance carrier.

Benefit payments and claims

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

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

Claim type and timeframes

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

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

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

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

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

know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

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

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

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

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

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

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

Complaints, claim decisions and appeals procedures

The difference between a complaint and an appeal

A Complaint

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

An Appeal

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

Claim decisions and appeal procedures

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

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

Appeals of adverse benefit determinations

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

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

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

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

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

Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having you fill out an authorized representative form telling us that you are allowing the provider to appeal for you.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

Timeframes for deciding appeals

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

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

Exhaustion of appeals process

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

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

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

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

External review

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

You have a right to external review only if:

- Our claim decision involved medical judgment.

- We decided the service or supply is not **medically necessary** or not appropriate.
- We decided the service or supply is **experimental, investigational, or unproven**.
- You have received an adverse determination.

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

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

You must submit the Request for External Review Form:

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

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

Aetna will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information.

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

How long will it take to get an ERO decision?

We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

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

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

For initial adverse determinations

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

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

For final adverse determinations

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

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

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

Recordkeeping

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

Fees and expenses

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

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet

We prepared this booklet 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 booklet when we administer your coverage.

How Aetna administers this plan

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

Who's responsible to you

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

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

Claim administrator

Aetna's authority as claim administrator

Aetna has been designated as claims administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Coverage and services

Your coverage can change

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

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

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

You have special rights if we rescind your coverage:

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

Some other money issues

Legal action

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

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

Assignment of benefits

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

Financial sanctions exclusions

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

Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would

then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

Your health information

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

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

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

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental, investigational or unproven (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.

Glossary

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

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

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

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

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

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

Designated network provider
A **network provider** listed in the directory under *Best results for your plan* as a **provider** for your plan.

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

Emergency medical condition
An acute, 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, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
    - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
    - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

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.

Institutes of Quality® (IOQ) (Bariatric, Orthopedic and Cardiac)
A national network of facilities publicly recognized, high-quality, high-value health care providers. These providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as efficiency criteria.

Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity. IOQ Bariatric Surgery procedures include: gastric bypass, adjustable gastric band and sleeve method
IOQ Cardiac Care services include Cardiac Medical Intervention, Heart Surgery and Heart Rhythm Disorders.
IOQ Orthopedic Care services include Spine Surgeries and Total Joint Replacement.

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

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

Medically necessary, medical necessity
Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:
- In accordance with "generally accepted standards of medical practice"
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease

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

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions

under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *Contact us* section for how.

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

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

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

Non-designated network provider
A **provider** listed in the directory under the *All other results* tab as a **provider** for your plan.

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

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

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

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

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

- General practitioner

- Family **physician**
- Internist
- Nurse Practitioner
- Physician Assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group (primary care office)

Provider

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

Psychiatric hospital

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

Recognized charge

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

Residential treatment facility

A facility that provides **mental health disorder** services or **substance related disorder** services and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **behavioral health provider** (RN or master's level) requiring full-time residence and participation
- Has a licensed **behavioral health provider**, (RN or master's level) on-site 24 hours per day 7 days per week, and is:
    - Credentialed by us, or
    - Certified by Medicare, or
- Accredited by The Joint Commission (TJC); The Committee on Accreditation of Rehabilitation Facilities (CARF); The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP); or The Council on Accreditation (COA)

Retail pharmacy

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

Room and board

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

Semi-private room rate

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

Skilled nursing facility

A facility that provides skilled nursing care and meets the following requirements:

- Is licensed and operated in accordance with applicable state and federal law
- Provides treatment under the direction of an appropriately licensed **physician** for the level of care provided
- Maintains a written treatment plan prepared by a licensed **provider** (RN or master's level) requiring full-time residence and participation
- Has a licensed **provider** (RN or master's level) on-site 24 hours per day 7 days per week, and is:
  - Credentialed by us, or
  - Certified by Medicare, or
  - Accredited by The Joint Commission (TJC) or The Committee on Accreditation of Rehabilitation Facilities (CARF)

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

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

Stay

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

Substance related disorder

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

Surgery, surgical procedure

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

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation

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

Telemedicine

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

Terminal illness

A medical prognosis that you are not likely to live more than 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 Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

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

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 or other services, call 1-888-982-3862.

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 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance

TTY: 711

To access language services at no cost to you, call 1-888-982-3862.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó kojį' hólne' 1-888-982-3862. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-888-982-3862. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-888-982-3862 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-888-982-3862 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-888-982-3862 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-888-982-3862। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန် 1-888-982-3862 သို့ ဖုန်းခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-888-982-3862. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-982-3862. (Chamorro)

ᏣᎩᏍᏗ ᏚᏬᏂᎯᏍᏗ ᎤᏳᎾᏓᏛᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏱᎩ, ᏫᏑᎯᏏᎳᏛᏏ 1-888-982-3862. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-888-982-3862. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-888-982-3862. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-888-982-3862. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-982-3862. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-888-982-3862. (Gujarati)

No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i kēia helu kelepona 1-888-982-3862. Kāki ‘ole ‘ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-888-982-3862 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-982-3862. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-888-982-3862. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1-888-982-3862. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-888-982-3862. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

လာတ်ကမၤန့ၣ်ကျိဉ်အတ်မၤစၢၤအတ်ဖဲ:တ်မၤတဖဉ်လၢတအိဉ်ဒီး:အပူၤလၢကဘဉ်ဟုဉ်အီၤအဂီၢ်ဘဉ်နှဉ် ကိး: 1-888-982-3862 တက့ၢ်. (Karen)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-888-982-3862. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-888-982-3862. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ສຽຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-888-982-3862. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-888-982-3862 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-888-982-3862. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-888-982-3862. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-888-982-3862मा टेलफिोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wɛ̈ɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1-888-982-3862. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-888-982-3862. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-982-3862. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-888-982-3862. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862. (Swahili)

[illegible]

(Syriac-Assyrian) 1-888-982-3862

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-888-982-3862 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-888-982-3862. پر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862. (Vietnamese)

צו צוטריט שפּראַך באַדינונגען אין קיין פּרייַז צו איר, רופן 1-888-982-3862. (Yiddish)

Lati wọnú awọn isẹ̀ èdè l'ọfẹ fun ọ, pe 1-888-982-3862. (Yoruba)