Member Handbook

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Welcome

Understanding your health care benefits is important. Whether you need **preventive care** to help you maintain good health or you are facing a serious health challenge, knowing how your health benefits work can make life easier. This handbook tells you about the COVA HealthAware Plan, an option under the Commonwealth of Virginia Health Benefits Program for eligible employees and retiree group participants and their eligible family members.

This handbook explains the COVA HealthAware Plan provisions, including:

- Health reimbursement arrangement (HRA)
- Medical benefits, which also include:
  - Behavioral health benefits
  - **Prescription** drug benefits
  - Basic dental benefits (diagnostic and preventive)
  - Routine vision and hearing exams
- Employee Assistance Program
- Optional expanded dental benefits
- Optional expanded vision benefits

These benefits are collectively referred to in this handbook as "the Health Plan," "your Health Plan" or "the Plan." Unless noted otherwise at the beginning of a chapter, the terms "you" and "your" refer to a covered employee of the Commonwealth of Virginia (the State) or a covered family member. The term "employee" includes covered retirees, survivors and long-term disability participants.

Your claims under the Plan are administered by Aetna Life Insurance Company (Aetna). Aetna is referred to as the "**Claim administrator**" in this handbook.

Your Health Plan does not cover everything. There are specific exclusions for which the Plan will never pay. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if you receive the service without observing all the conditions and limits under which the service is covered. Finally, except for **preventive care**, unless you have funds available from your health reimbursement arrangement or you reach your annual **out-of-pocket maximum**, you almost always have to pay for part of the cost of treatment.

Your health benefits are contractual in nature. The rules that govern the Plan are described in this handbook, including:

- The services eligible for reimbursement;
- The conditions under which the services are covered;
- The limits of coverage; and
- The benefits that may be payable under the specified conditions.

This means, in part, that if you or your provider thinks a service should be covered, that does not make it a covered service. The same is true even when the issue is life or death: a service is not covered simply because you or your **physician** believes you need the service or because the service is the only remaining treatment that might (or might not) save your life.

You are responsible for knowing what is covered and the limits and conditions of coverage. Furthermore, the terms and conditions of your coverage can be changed without your consent if proper notice is given to you.

Know Your Plan

This handbook describes the services and supplies that the Health Plan is designed to cover and the rules that apply to that coverage. Use the handbook as a tool to help you and your **physician** make informed decisions about the course of treatment that is appropriate for you. You and your **physician** are ultimately responsible for deciding on the course of treatment to be followed in any situation, regardless of whether it appears the Plan will pay for that care.

Your Health Plan pays its part of the cost of **medically necessary** health services needed to diagnose and treat illnesses and injuries. Services that are not **medically necessary** for the diagnosis and treatment of illnesses or injuries are not eligible for reimbursement. For example, services designed primarily to improve your personal appearance are not eligible for reimbursement.

There are rules that apply to all benefits. See Benefit Basics to learn about important features of the Plan. In addition, there are some services for which the Plan will never pay. Each benefit-specific chapter includes a description of what is not covered. Finally, refer to the Definitions chapter for an explanation of many of the terms used in this booklet. Words and phrases explained in Definitions will appear in **bold type**. The information in these sections is important because it describes how the **Claim administrator** determines exactly what your Health Plan covers.

Health Care Reform

The COVA HealthAware Plan is a non-grandfathered health plan as defined by the Patient Protection and Affordable Care Act (PPACA). This means that the Plan must comply with the applicable rules of PPACA.

Please read this handbook carefully and refer to it when you need to understand how your Health Plan works. If you have questions or need help:

- Refer to Resources, Tools and Programs; or
- Call the Aetna Health Concierge at **1-855-414-1901**.

This handbook may be printed at any time from the following website: **www.dhrm.virginia.gov**.

Your ID Card

You will receive an ID card when you enroll in the COVA HealthAware Plan. If you enroll your spouse, you will receive two ID cards. You may request additional cards for other covered family members by calling the Health Concierge at **1-855-414-1901**. If you elect the optional vision plan, you'll receive two vision ID cards. You are encouraged to carry your ID card(s) with you at all times. Present your card to providers before receiving services, and to network pharmacies when filling a **prescription**.

If you lose your card, call the Health Concierge at **1-855-414-1901** or log on to Aetna Navigator at **www.covahealthaware.com** to request a replacement.

Your Plan at a Glance

This chapter provides an overview of the health reimbursement arrangement (HRA) that is part of your Health Plan. You will also find a summary of cost sharing and covered services for the medical coverage under your Health Plan, plus an overview of the optional expanded dental and vision benefits that are available to you. Additional and more detailed information about covered services can be found in the benefit-specific chapters that follow this overview.

There are two levels of COVA HealthAware benefits – Basic and Optional:

- Basic benefits:
  - Health reimbursement arrangement
  - Medical, including behavioral health care, **prescription** drug coverage, diagnostic and preventive dental services and routine annual vision and hearing exams
  - Employee Assistance Program
- Optional benefits are available, per plan provisions, for an additional monthly contribution:
  - Expanded dental, covering primary dental services such as fillings and periodontal care; major dental services such as **dentures**, **crowns** and inlays; and **orthodontic treatment**
  - Expanded vision coverage for lenses, frames and contact lenses (expanded vision can't be elected without expanded dental)

Your Basic Benefits: Summary of Benefits

Health Reimbursement Arrangement (HRA)

The HRA Fund: Contributions at the start of the Plan year	
Employee*-Only	$600
Employee* and Spouse	$1,200

* "Employee" includes retiree group participants (retirees, survivors and LTD participants)

Enrollment after the start of the **plan year** will result in prorating the HRA contribution. See New Hires and Qualifying Mid-Year Events for more information.

You can earn additional contributions to the HRA by completing certain "Do-Rights." See Earn Additional HRA Contributions by Completing "Do-Rights" for more information.

Medical Cost Sharing

Refer to Benefit Basics for more information about in- and out-of-network cost sharing.

Plan Feature	In-Network	Out-of-Network
Annual Deductible		
Individual	$1,500 per **plan year**	$3,000 per **plan year**
Two Person or Family	$3,000 per **plan year**	$6,000 per **plan year**
Annual Out-of-pocket maximum (includes **deductible**)		
Individual	$3,000 per **plan year**	$6,000 per **plan year**
Two Person or Family	$6,000 per **plan year**	$12,000 per **plan year**
Lifetime Maximum Benefit		
Individual or Family	Unlimited	

Keep in Mind

Your **deductible** and **coinsurance** costs for covered services will be paid by available funds in your HRA.

The medical **deductible** and **out-of-pocket maximum** do not apply to the preventive dental coverage that is part of your basic benefits. See Basic Dental Cost Sharing for more information.

Covered Medical Services

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge***1)
Preventive care*2		
Routine Physical Exam*3 • 1 exam per **plan year**	The Plan pays 100%*4 No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Well-Child Visit*3 • 1st 12 months: 7 exams • 13-24 months: 3 exams • 25-36 months: 3 exams • age 3-26 years: 1 exam per **plan year**	The Plan pays 100%*4 No **deductible**	You pay 40% after the **deductible**; Plan pays 60%

*1 The Plan's out-of-network benefit is based on the **recognized charge**. You pay the **deductible** and **coinsurance** shown, plus any costs that are over the **recognized charge**.

*2 You can learn more about **preventive care** coverage on Aetna's website at **www.aetna.com** or by calling the Aetna Health Concierge at **1-855-414-1901**.

*3 The Plan pays 100%, no **deductible**, for the first in-network exam or procedure per **plan year** (whether routine or diagnostic). No coverage for routine exams/procedures for the remainder of the **plan year**. Any additional in-network diagnostic exam or procedures in that year will be covered at 80% after the **deductible**.

4 Includes in-network immunizations, lab and X-ray services completed within 5 calendar days before or after the annual exam.

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge***[1])
Screening and Counseling • obesity — up to age 22: unlimited visits — age 22 and over: up to 26 visits per 12-month period (healthy diet counseling limited to 10 visits) • use of tobacco products: up to 8 counseling sessions per 12-month period • misuse of alcohol or drugs (screening services not provided by a behavioral health provider): up to 5 visits per 12-month period • women's health screenings and counseling	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Preventive Immunizations • Per recommended protocol	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Routine Prostate Screening*[3] • 1 prostate-specific antigen (PSA) test and digital rectal exam (DRE) per **plan year** for men	The Plan pays 100%, no **deductible***[4]	You pay 40% after the **deductible**; Plan pays 60%
Routine Colorectal Cancer Screening*[3] • 1 screening per **plan year**	The Plan pays 100% No **deductible***	You pay 40% after the **deductible**; Plan pays 60%
Routine Annual Ob/Gyn Exam*[3] *(includes one Pap smear and related lab fees)* • 1 exam per **plan year**	The Plan pays 100% No **deductible***	You pay 40% after the **deductible**; Plan pays 60%
Routine Mammogram*[3] • 1 mammogram per **plan year**	The Plan pays 100% No **deductible***	You pay 40% after the **deductible**; Plan pays 60%
Routine Vision Exam • 1 exam per **plan year**	The Plan pays 100% No **deductible**	The Plan pays 100% No **deductible**
Routine Hearing Exam • 1 exam per **plan year**	The Plan pays 100% No **deductible**	The Plan pays 100% No **deductible**
Outpatient Care		
Office Visit - Primary Care **Physician**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Office Visit - **Specialist**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

*3 The Plan pays 100%, no **deductible**, for the first in-network exam or procedure per **plan year** (whether routine or diagnostic). No coverage for routine exams/procedures for the remainder of the **plan year**. Any additional in-network diagnostic exam or procedures in that year will be covered at 80% after the **deductible**.

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge**)
Outpatient Care (cont'd)		
Walk-in clinic	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Emergency Room		
• **emergency care**	You pay 20% after the **deductible**; Plan pays 80%	You pay 20% after the **deductible**; Plan pays 80%
• non-**emergency care**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Urgent Care	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Hospital Outpatient Care	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Outpatient Surgery *(facility or outpatient **hospital**)*	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Second Surgical Opinion	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Behavioral Health Treatment		
• outpatient	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• **partial hospitalization**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Substance Abuse Treatment		
• outpatient	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• **partial hospitalization**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Inpatient Care	Refer to **Precertification** for information about the **precertification** process for inpatient care.	
Inpatient **Hospital** Care *(room and board are covered up to the **hospital**'s **semi-private room rate**)*	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Physician's Services in the **Hospital**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Pre-Admission Testing	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Inpatient Surgery	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Anesthesia *(includes acupuncture by a licensed provider in lieu of anesthesia)*	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Inpatient Behavioral Health Treatment	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Inpatient Substance Abuse Treatment	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge**)
Alternatives to Inpatient Hospital Care	Refer to **Precertification** for information about the **precertification** process for alternatives to **hospital** inpatient care.	
Skilled Nursing Facility Care • up to a maximum of 180 days per confinement	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Home Health Care • up to 90 visits per **plan year**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Hospice care		
• inpatient	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• outpatient	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Private Duty Nursing	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Other Covered Services		
Ambulance		
• **medically necessary** transport	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• transport for convenience or other transport that is not **medically necessary**	Not covered	Not covered
Applied Behavior Analysis/Habilitation Therapy *(Autism Spectrum Disorder treatment for children age two through six)* • $35,000 maximum per **plan year**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Chiropractic Care (spinal manipulation treatment • up to 30 visits per **plan year**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Diagnostic Complex Imaging *(includes MRI, PET scan, and CT scan)*	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Diagnostic X-Ray and Lab Procedures	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Durable Medical and Surgical Equipment and Supplies	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Early Intervention Services • covered for family members from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (DBHDS) as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA)	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Prosthetic Devices • includes coverage for up to 3 wigs per **plan year**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge**)
Other Covered Services (cont'd)		
Voluntary Sterilization (men)	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Voluntary Sterilization (women)	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Contraceptive Counseling		
• first 2 visits in a 12-month period	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
• additional visits	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Contraceptive Devices and Injectables *(provided and billed by your **physician** - includes insertion/administration)*		
• generic devices/injectables and devices with no generic equivalent	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
• brand-name Refer to **Prescription** Drug Coverage for information about oral contraceptives.	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
Infertility Services		
• diagnosis and treatment of the underlying cause of **infertility**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• ovulation induction, artificial insemination and advanced reproductive technologies (ART)	Not covered	Not covered
Routine Maternity Care* *(**physician**'s services)*		
• initial visit to confirm pregnancy	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• routine prenatal office visits	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
• delivery and postnatal care	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

* The benefits shown here are for routine maternity care and services provided by your Ob/Gyn, including routine prenatal care, delivery services and postnatal care. Additional services such as laboratory tests and care that are required due to complications of pregnancy are not considered routine maternity care. Call the Health Concierge at **1-855-414-1901** if you have questions about coverage for care during your pregnancy.

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge**[*1])
Other Covered Services (cont'd)		
Breast Feeding Support and Supplies		
• lactation counseling		
- visits 1-6 in a 12-month period	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
- additional visits	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• breast pumps and supplies - 1 manual or electric pump per 36-month period	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Therapy Services *(physical, occupational, speech therapy)*	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

***Prescription** Drug*

Prescription Drugs	In-network pharmacy	Out-of-Network Pharmacy
Retail Pharmacy *(up to a 90-day supply)*		
Generic drug		
• **generic drug**s (except generic contraceptives)	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• generic contraceptive drugs and devices*[5]	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Brand-name drug If a generic is available, you will pay the cost difference between generic and brand-name, plus your **coinsurance**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

Prescription Drugs	In-network pharmacy	Out-of-Network Pharmacy
Mail-Order Prescription drugs *(up to a 90-day supply)*		
Generic drug		
• **generic drug**s (except generic contraceptives)	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%
• generic contraceptive drugs and devices*[5]	The Plan pays 100% No **deductible**	You pay 40% after the **deductible**; Plan pays 60%
Brand-name drug If a generic is available, you will pay the cost difference between generic and brand-name, plus your **coinsurance**	You pay 20% after the **deductible**; Plan pays 80%	You pay 40% after the **deductible**; Plan pays 60%

*[5] Includes devices with no generic equivalent.

Basic Dental Cost Sharing

Plan Feature	In-Network	Out-of-Network
Annual Deductible		
Individual	No **deductible**	No **deductible**
Calendar Year Maximum Benefit		
Individual	Unlimited	

Covered Basic Dental Services

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge***)
Preventive care		
Includes: • routine oral exams: 2 per **plan year** • problem-focused oral exams: 2 per **plan year** • cleanings: 2 per **plan year** • **fluoride** applications for children under age 19 : 2 treatments per **plan year** • sealants for children under age 19: 1 application to permanent molars per 3-year period • **bitewing** X-rays: 2 sets per **plan year** • full-mouth X-rays: 1 set per 3-year period (including Panorex) • vertical **bitewing** X-rays: 1 set per 3-year period • periapical X-rays • space maintainers • occlusal guards: 1 set per 3-year period to treat bruxism (teeth grinding) • non-surgical treatment of temporomandibular joint (TMJ) disorder (X-rays and **appliances**)	The Plan pays 100% No **deductible**	The Plan pays 100% No **deductible**

* The Plan's out-of-network benefit for basic dental services is based on the **recognized charge**. You pay any costs that are over the **recognized charge**.

Your Optional Benefits: Summary of Benefits

Optional Expanded Dental Plan Cost Sharing

Plan Feature	In-Network	Out-of-Network
Annual Deductible *applies to basic and major restorative care*		
Individual	$50 per **plan year**	$50 per **plan year**
Two-Person	$100 per **plan year**	$100 per **plan year**
Family	$150 per **plan year**	$150 per **plan year**
Plan year Maximum Benefit *applies to basic and major restorative care*		
Individual	$2,000 per **plan year**	$2,000 per **plan year**
Orthodontia Lifetime Maximum Benefit		
Individual	$2,000	$2,000

Covered Optional Expanded Dental Plan Services

Covered Services	In-Network (based on **negotiated charge**)	Out-of-Network (based on **recognized charge***)
Primary Care		
Includes: • simple extractions • fillings • oral surgery • periodontal therapy: 4 separate quads per 2-year period • periodontal maintenance: 2 per **plan year** following active periodontal therapy • **endodontics**, including molar **root canal therapy**	You pay 20% after the **deductible**; Plan pays 80%	You pay 20% after the **deductible**; Plan pays 80%
Major/Complex Restorative Care		
Includes: • **inlays**, **onlays** and **crowns** • fixed **bridgework** • **dentures**	You pay 50% after the **deductible**; Plan pays 50%	You pay 50% after the **deductible**; Plan pays 50%
Orthodontia Treatment		
Orthodontia Treatment	You pay 50%; Plan pays 50% No **deductible**	You pay 50%; Plan pays 50% No **deductible**

* The Plan's out-of-network benefit is based on the **recognized charge**. You pay the **deductible** and **coinsurance** shown, plus any costs that are over the **recognized charge**.

Covered Optional Expanded Vision Services

Covered Services	In-Network	Out-of-Network
Exams		
Standard Contact Lens Fitting/Follow-Up	You pay $40	Not covered
Premium Contact Lens Fitting/Follow-Up	You pay 90% of retail cost	Not covered
Eyeglass Lenses and Lens Options		
You can use your lens coverage once per plan year to purchase either 1 pair of eyeglass lenses or 1 order of contact lenses (see the next page for more information about ordering contact lens)		
Lenses		
• single vision	You pay $20 **copay**, then the Plan pays 100%	The Plan reimburses up to $50; you pay the balance
• bifocal vision	You pay $20 **copay**, then the Plan pays 100%	The Plan reimburses up to $75; you pay the balance
• trifocal vision	You pay $20 **copay**, then the Plan pays 100%	The Plan reimburses up to $100; you pay the balance
• lenticular	You pay $20 **copay**, then the Plan pays 100%	The Plan reimburses up to $100; you pay the balance
• standard progressive vision	You pay $85 **copay**, then the Plan pays 100%	The Plan reimburses up to $75; you pay the balance
• premium progressive vision	• 20% discount applies to retail cost. • Plan pays $120 • You pay $85 **copay** plus balance after discount and the Plan's allowance	The Plan reimburses up to $75; you pay the balance
Lens Options You can take advantage of discounts on the following:		
• UV treatment	You pay $15	Not covered
• tint (solid and gradient)	You pay $15	Not covered
• standard plastic scratch coating	You pay $15	Not covered
• standard polycarbonate lenses (adult or child)	You pay $40	Not covered
• standard anti-reflective coating	You pay $45	Not covered
• polarized/other add-ons	You pay 80% of retail	Not covered

Covered Services	In-Network	Out-of-Network
Contact Lenses *(in lieu of eyeglass lenses)*		
You can use your lens coverage once per plan year to purchase either 1 pair of eyeglass lenses or 1 order* of contact lenses. * An "order" is up to a one-year supply of contact lenses. Since the Plan's benefit is limited to 1 order per **plan year**, consider ordering the largest supply at once that is practical in your situation.		
Conventional contact lenses	Plan pays $100 15% discount applies to balance	The Plan reimburses up to $80; you pay the balance
Disposable contact lenses	Plan pays $100	The Plan reimburses up to $80; you pay the balance
Medically necessary contact lenses	Plan pays 100%	The Plan reimburses up to $210; you pay the balance
Frames		
You can use your frame coverage once per plan year		
Any frame available, including frames for **prescription** sunglasses	Plan pays $100 20% discount applies to balance	The Plan reimburses up to $80; you pay the balance
Discounts		
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands		
Additional pairs of eyeglasses or **prescription** sunglasses. Discount applies to purchases made after the Plan allowances have been exhausted.	Up to a 40% discount	No discount
Non-covered items such as cleaning cloths and contact lens solution	20% discount	No discount
Lasik laser vision correction or PRK from U.S. Laser Network only. Call **1-800-422-6600**	• 15% discount applies to retail price; or • 5% discount applies to promotional price	No discount
Retinal imaging *(not related to a medical condition)*	You pay a discounted fee, up to $39, where available	No discount
Replacement contact lenses	Order online and save. Visit **www.aetnavision.com** for details.	No discount

Resources, Tools and Programs

When you have questions or need help, here are some of the resources, tools and other programs that are available to you. More information and descriptions of additional resources follow the chart.

Resource	Overview of Services	How to Contact
Aetna Health Concierge More information about the Aetna Health Concierge follows this chart.	Contact the Health Concierge when: • You have questions about the Plan's benefits • You want to obtain preauthorization for a service (**precertification**) • You have a question about a claim • You need a new or an additional ID card	Phone: **1-855-414-1901** Hours: Monday-Friday 8:00 a.m. – 6:00 p.m. ET Online: **www.covahealthaware.com** For behavioral health care, you can also call 1-800-424-4047.
Employee Assistance Program (EAP) See Employee Assistance Program for a detailed description of services.	Call the EAP when you need help with personal concerns such as: • Stress • Marital and family issues • Substance abuse	Phone: **1-888-238-6232** Online: **www.mylifevalues.com** User name: COVA Password: COVA Hours: available 24 hours a day, 7 days a week
Aetna Vision	Contact Aetna Vision when: • You have questions about the optional Plan's benefits • You have a question about a claim • You want to find a provider in the network	Phone: **1-877-497-4817** Hours: Monday-Saturday: 7:30 a.m. – 11:00 p.m. EST Sunday: 11:00 a.m. – 8:00 p.m. EST Online: **www.covahealthaware.com** for provider information You can also go to **www.aetnavision.com** for information about vision wellness, to see benefit details and to learn more about discounts on vision products
Aetna Navigator® - Your Secure Member Website More information about Aetna Navigator follows this chart.	Use your member website when you need: • Claim status information • A replacement ID card • Claim forms • Access to tools that help you manage your health care • To check your HRA balance • To track your **deductible** and out-of-pocket expenses	Online: **www.covahealthaware.com**

Resource	Overview of Services	How to Contact
ActiveHealth Management More information about ActiveHealth Management follows this chart.	Use **MyActiveHealth.com/COVA** to: • Take your health assessment • Use trackers and tools for healthy eating and exercise • Find health information • Arrange for biometric screening • Work with a health coach	Online: **www.MyActiveHealth.com/COVA** Phone: **1-866-938-0349** Hours: Monday-Friday: 8:30 a.m. – 11:00 p.m. EST Saturday: 9:00 a.m. 0 2:00 p.m. EST
Informed Health® Line More information about Informed Health Line follows this chart.	Call the Informed Health Line when you are looking for information about: • Medical procedures and treatment options • How to describe symptoms and ask the right questions when talking with your health care provider	Phone: **1-800-556-1555** TDD: **1-800-270-2386** Hours: available 24 hours a day, 7 days a wee
Your Commonwealth of Virginia Benefits Administrator	Call your Benefits Administrator if you have questions about: • Eligibility • Enrollment • Disenrollment • Qualifying events	• *Active employees and their covered family members:* contact your employing agency's Human Resources Department. • *Retiree group participants:* refer to your annual rate materials to identify your Benefits Administrator.
The Department of Human Resource Management (DHRM) Office of Health Benefits	Contact the DHRM if you need to bring an issue to the attention of the Plan Administrator.	E-mail: **ohb@dhrm.virginia.gov**

Health Concierge

The Aetna Health Concierge is a single point of contact to help you understand and maximize your health care benefits. The Health Concierge will also help you identify and take advantage of the many wellness offerings available to you under the Health Plan. Call **1-855-414-1901** to talk with the Health Concierge.

Online Provider Directory

DocFind® is Aetna's online provider **directory**. DocFind gives you the most recent information on the doctors, **dentist**s, hospitals and other providers in the Aetna network. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location, hours, parking and accessibility for individuals with disabilities.

To access DocFind, go to **www.covahealthaware.com** and follow the prompts. For your Health Plan, click on the *Aetna HealthFund Plans/Aetna Choice POS II (Aetna HealthFund)* network

Do You Live in a Rural Area?

If you live in one of the areas listed below, you can also search for providers in the DocFind Rural **Directory**. Click on the *DocFind®* link on **www.covahealthaware.com**, select *Tools & Resources*, then click on *Rural PPO Program*. When prompted to select a plan type, click on *Rural Choice POS II*.

Accomack County
Augusta County
Brunswick County
Greene County
Greensville County
Halifax County
Madison County
Mecklenburg County
Northampton County
Page County
City of Staunton
City of Waynesboro

Aetna Navigator: Health Information Website

Use Aetna Navigator®, your secure member website at **www.covahealthaware.com,** as your online resource for personalized benefit and health information. Once you register, you'll have access to secure, personalized features, such as benefit and claim status, as well as specific health and wellness information. The chart at the beginning of this chapter lists some of the information you can find on Aetna Navigator. You can also contact the Health Concierge online and access useful tools that help you manage your health care, such as:

- *Member Payment Estimator,* a tool that allows you to research the costs of office visits, tests and selected procedures in your area.
- *Price-A-Drug*℠, allows you to:
  - Estimate the cost of a **prescription** drug from a local retail **pharmacy** or a mail-order **pharmacy**, including comparing drug costs by **pharmacy**.
  - Compare the costs of generic and **brand-name drugs**.
- ***Hospital** Comparison Tool,* helps you compare area hospitals on measures that are important to your health.
- *Aetna SmartSource*℠, a search engine that scans Aetna's online resources and pulls together information that's specific to you, based on where you live, the plan you're enrolled in and your personal profile.
  Just enter a condition or symptom, and SmartSource will give you links to useful information, such as:
  - A HealthMap® that lets you explore your health topic — including symptoms, treatment options, preventive steps and more — to help you see and plan for the road ahead.
  - The names of local doctors in Aetna network who specialize in treating the condition.
  - Estimated health care costs.
  - Aetna programs and discounts that may help you manage your health care needs.
  - Health articles and tips.

To register for Aetna Navigator, go to **www.aetna.com** or **www.covahealthaware.com** and click on *Register*. You must have your member ID number (listed on your ID card) to complete registration.

Active Health Management – MyActiveHealth.com/COVA

Your MyActiveHealth℠ site gives you tools to protect and improve your health. Once you create your MyActiveHealth personal health record at **www.MyActiveHealth.com/COVA**, your MyActiveHealth site becomes your gateway for accessing and managing your health information.

Take the health assessment, a confidential questionnaire, to get an instant look at your current health risks – and a starting point to make improvements.

The site also gives you:

- Your personal health information in a simple, organized way. You can find your medical history, medical conditions, medications and doctors, and you can share this information with your doctor and access it at home and on your mobile device.
- Suggestions for healthy actions based on your health assessment. Talk to your doctor and pick the actions that are right for you.
- Trackers and other tools for healthy eating and exercise.
- Links to helpful tools and information, such as:
  - Symptom checker;
  - Recipe finder;
  - Drug interaction checker;

- Online coaching modules;
- Nutritional scoring system;
- Health news – videos and articles that are updated daily; and
- Custom links, selected for you based on your current health.

In addition, the Rewards Center lets you see the status of available incentives and check on the next steps you need to take to earn HRA incentives. Refer to Earn Additional HRA Contributions by Completing "Do-Rights" for more information.

The Health and Wellness Programs section of this handbook provides more information about ActiveHealth Management programs.

Your Personal Information Is Secure

All online tools are secure, so your privacy is protected.

Informed Health® Line

Get the help and information you need to make good health care decisions – 24 hours a day, 7 days a week – through Aetna's Informed Health Line.

Informed Health's tools and resources can help you make more informed decisions about your care, communicate better with your doctors, and save time and money, by showing you how to get the right care at the right time.

Call the Informed Health Line (IHL) to:

- Speak directly to a registered nurse about a wide variety of health and wellness topics.
- Access the health video library. After talking with you, the IHL nurse will send you an e-mail that contains a link to a video that gives you more information about related health topics. You can watch the video as often as you want or call the IHL nurse to request more videos.

Clinical Policy Bulletins

Aetna uses its Clinical Policy Bulletins (CPBs) as a resource when making benefit and claim decisions. CPBs are written on selected health care topics, such as new technologies and new treatment approaches and procedures. The CPBs describe whether Aetna has determined that a service or supply is **medically necessary**, based on clinical information.

You can find the CPBs at **www.aetna.com**. The language of the CPBs is technical because it was developed for use in benefit administration, so you should print a copy and review it with your doctor or **dentist** if you have questions.

Keep in Mind

- The CPBs define whether a service or supply could be considered **medically necessary**, but they do not define whether the service or supply is covered by the Plan. This handbook describes what is covered and what is not covered by the Plan.
- If you have questions about your coverage, you can contact the Health Concierge at the toll-free telephone number on your ID card.

Advanced Illness Resources

The Aetna Compassionate Care℠ program offers services and support when you are facing difficult decisions about an advanced illness. The program's nurse case managers work with doctors to:

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient's pain and symptoms.

Call the Aetna Health Concierge at **1-855-414-1901** to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at **www.aetnacompassionatecare.com**.

Transplant and Special Medical Care

The National Medical Excellence Program® (NME) can help you get care and helpful resources when you need them most – with one-on-one support through all phases of treatment. The program includes:

- *National Transplant Program* – coordinates care and provides access to covered treatment through the *Institutes of Excellence™ Transplant Network*.
- *National Special Case Program* – assists members with rare or complex conditions requiring specialized treatment to evaluate treatment options and obtain appropriate care.
- *Out-of-Country Care Program* – supports members who need emergency NME inpatient medical care while temporarily traveling outside the United States.

These services must be preauthorized by Aetna.

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one **companion,** including round trip (air, train or bus) transportation costs (coach class only) or mileage, parking and tolls if traveling by auto.

Benefits for travel and lodging expenses are subject to a maximum of $10,000 per transplant or procedure. Lodging expenses are subject to a $50 per night maximum per person, or $100 per night total.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest of the following dates:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date your coverage terminates under the Plan.

Keep in Mind

- The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does ***not*** cover treatment considered **experimental and investigational** (as determined by Aetna).
- Travel and lodging expenses must be approved in advance by Aetna. The Plan does ***not*** cover expenses that are not approved.

Medication Therapy Management Program

Starting October 1, 2013, your Plan will include a Medication Therapy Management (MTM) Program designed to enhance the effectiveness of participants' medication therapy by offering one-on-one confidential reviews of medications directly with a pharmacist. In these sessions, the pharmacist can educate individuals about drug regimen compliance, possible drug reactions and other issues relating to their conditions. Participation in the program is voluntary and completely confidential.

Eligible plan participants (not including minor children) will be identified by the following criteria. They must:

- Have three or more of the following chronic conditions: asthma, COPD, depression, diabetes, heart failure, high blood pressure, high cholesterol or osteoporosis; and
- Take seven or more medications for chronic conditions.

Each qualifying participant will be eligible for one initial and up to three follow-up consultations within a 365-day period. The program will be administered by Mirixa. However, program representatives will identify themselves as being from Aetna.

Here is how the program works:

- The participant fills a **prescription**
- Claims are analyzed to determine eligibility for the MTM program
- If a participant is identified as being eligible, a notification is sent to the **pharmacy**
- The pharmacist consults with the participant and may also involve the member's **physician** to review therapy concerns
- The pharmacist documents communications and outcomes with the participant.

The program also has other benefits for improving participant health, including a review of allergies, medical conditions and medications; assistance with drug compliance and identification of gaps in care or adherence to therapy.

Benefit Basics

This section describes important features of the Health Plan. To learn how these features apply to each benefit, refer to Your Plan at a Glance.

> ***Please Note***
> Certain features do not apply to every benefit. For example, the dental benefit does not include an **out-of-pocket maximum**. Refer to Your Plan at a Glance to learn more.

The Health Plan pays benefits for covered expenses. You must be covered by the Plan on the date you incur a covered medical expense. You incur the charge for a service on the date you receive the service. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

The Provider Network

The Health Plan gives you the freedom to choose any doctor or other health care provider when you need care. How that care is covered and how much you pay out of your own pocket depend on whether the expense is covered by the Plan and whether you choose an **in-network provider** or an **out-of-network provider**.

Doctors, **dentist**s, hospitals and other health care providers that belong to Aetna's network are called **in-network provider**s. When they join the network, providers agree to provide services or supplies at **negotiated charges**.

To find an **in-network provider** in your area:

- *Use DocFind at* **www.covahealthaware.com**. Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you're willing to travel. You can search the online provider **directory** for a specific doctor, type of doctor or all the doctors in a given zip code and/or travel distance. For more about DocFind, go to Resources, Tools and Programs.
- *Call the Health Concierge*. Your Health Concierge can help you find an **in-network provider** in your area. You can also request a printed listing of **in-network provider**s in your area without charge. The toll-free number for the Health Concierge is listed in Resources, Tools and Programs and printed on your ID card.

It's Your Choice

When you need care, you have a choice. You can select a doctor, **behavioral health provider**, **dentist** or facility that participates in the network (an **in-network provider**) or one that does not participate (an **out-of-network provider**).

- *If you use an **in-network provider***, you'll usually pay less out of your own pocket for your care. You won't have to fill out claim forms, because your **in-network provider** will file claims for you. In addition, your provider will make the necessary telephone call to start the **precertification** process when you must be hospitalized or need certain types of care. (See **Precertification** for more information.)
- *If you use an **out-of-network provider,*** you'll usually pay more out of your own pocket for your care. You may be required to file your own claims and you must make the telephone call if you want to get **precertification** of the services. (See Claims and Appeals and **Precertification** for more information.)

Your Plan at a Glance shows how the Plan's level of coverage differs when you use in-network versus **out-of-network provider**s. In most cases, you save money when you use **in-network provider**s.

The National Advantage™ Program

If you decide to receive medical care from **out-of-network provider**s, you may be able to save on the cost of your care by using a provider who participates in Aetna's National Advantage Program (NAP). This program gives you access to contracted rates for **hospital**, ancillary facility and **physician** services for NAP-participating **out-of-network provider**s. These rates are not the same as in-network **negotiated charge**s, but they give you a discount on the provider's usual fees, so you can save.

To find out whether or not NAP providers are available in your area, you can:

- Call the Health Concierge at **1-855-414-1901**; or
- Use DocFind at **www.covahealthaware.com**. Select the appropriate provider category and follow the prompts to do your search.

If you visit an NAP provider:

- Show your Aetna ID card.
- Don't pay at the time of service. The provider will submit a claim to Aetna.
- Your claim will be processed at the applicable contracted rate.
- You'll be billed for any applicable **coinsurance** or **deductible** based on the NAP contracted rate for covered services.

In an Emergency

You have coverage 24 hours a day, 7 days a week, anywhere in the world, if care is needed to treat an **emergency condition**. Care you receive for an **emergency condition** is covered as **in-network care** – even if the provider is not in the network – as long as Aetna determines that the condition qualifies as an emergency. If you get care in an out-of-network emergency setting for a non-**emergency condition**, your care will be covered at the out-of-network benefit level.

An emergency medical condition is a recent and severe condition, sickness or injury, including (but not limited to) severe pain, that would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual), possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy;
- Serious impairment to a bodily function(s);
- Serious dysfunction to a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

Examples of medical emergencies include:	
• heart attack or suspected heart attack	• loss of consciousness
• poisoning or suspected poisoning	• suspected overdose of medication
• severe shortness of breath	• severe burns
• uncontrolled or severe bleeding	• high fever (especially in an infant)

Services While Traveling Abroad

There are no network providers outside of the United States. However, all covered services received outside of the United States will be paid at the in-network reimbursement level based on billed charges. You must pay the cost incurred for covered services and file a claim in order for Aetna to process reimbursement per plan provisions. (Providers will not be paid directly.)

The appropriate Benefit Request Claim Form is available at http://www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html. There are separate forms for medical, dental and vision services.

An itemized bill for all services and medical records associated with the services for which reimbursement is being requested should accompany all claim forms. Aetna will be responsible for:

- converting foreign currency to US dollars;
- translating foreign claims and correspondence; and
- coding and processing foreign claims.

Key Terms

The following key terms are the foundation of the Plan. For more information about these important concepts and for additional terminology, see the Definitions section.

Medically necessary Services and Supplies

The Plan pays benefits only for **medically necessary** services and supplies. Refer to Definitions for more information about how Aetna determines medical necessity.

Allowable charge

The Plan's benefits are based on the **allowable charge** for a service. The **allowable charge** depends on whether you receive care from an **in-network provider** or an **out-of-network provider**:

- **In-network provider**s have agreed to charge no more than the **negotiated charge** for a service or supply that is covered by the Plan. You are responsible for any **deductible** or **coinsurance** that applies to the **negotiated charge**, but you are not responsible for an amount that exceeds the **negotiated charge** when you obtain care from a network provider.
- The Plan pays benefits for out-of-network services based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred that are above the **recognized charge**, in addition to your higher out-of-network **deductible** and **coinsurance** share. Any amount that you pay above the **recognized charge** will not apply to your **out-of-pocket maximum**.

Refer to Definitions for more information about how Aetna determines the **recognized charge** for a service or supply.

Non-Occupational Coverage

The Plan covers only expenses related to **non-occupational injury** and **non-occupational disease**.

Deductible

The **deductible** is the part of covered expenses you pay each **plan year** before the Plan starts to pay benefits.

There are different **deductible** levels for in-network and **out-of-network care**. **Deductible** expenses are cross-applied to both the in-network and out-of-network **deductible**s.

> ***Keep in Mind***
>
> A combined **deductible** applies to medical, behavioral health and **prescription** drug expenses. A separate **deductible** applies to optional dental coverage.
>
> Your Plan at a Glance shows you the **deductible** that applies to each benefit.

There are two types of **plan year deductible**:

- *Individual*: The individual **deductible** applies separately to each covered person in the family. When a person's **deductible** expenses reach the individual **deductible** shown in Your Plan at a Glance, the person's **deductible** is met. The Plan then starts to pay benefits for that person at the appropriate **coinsurance** percentage.

  If you are covered as a family member, you may not have to meet your individual **deductible** if the family **deductible** is met – see below for information
- *Family*: The family **deductible** for the medical plan applies to the family as a group of two or more (see below for separate dental **deductible** information). When the combined **deductible** expenses of all covered family members reach the family **deductible** shown in Your Plan at a Glance, the family **deductible** is met. The Plan then begins to pay benefits for all covered family members.
  - *Medical*: For a family with three or more covered members, the family **deductible** is met when the **deductible** amounts paid by all family members reach the family **deductible** of $3,000 in-network/$6,000 out-of-network, even if no family member reaches his or her individual **deductible**.
  - *Dental*: For a family with four or more covered members, the family **deductible** is met when the **deductible** amounts paid by all family members reach the family **deductible** of $150, even if no family member reaches his or her individual **deductible**.

> ***Keep in Mind***
>
> Amounts above the **recognized charge** do not count toward your annual **deductible**.

Coinsurance

Once you meet your **deductible**, the Plan begins paying benefits for covered expenses. The portion paid by the Plan is the Plan's benefit. When the Plan's benefit is less than 100%, you pay the balance. The part you pay is called your **coinsurance**.

The medical plan (including behavioral health and **prescription** drug benefits) has different **coinsurance** levels for in-network and **out-of-network care** for each type of covered expense. Refer to Your Plan at a Glance for more information.

Out-of-pocket maximum

The medical plan (including behavioral health and **prescription** drug benefits) puts a limit on the amount you pay for covered expenses out of your own pocket each year, called the **out-of-pocket maximum**.

- The individual **out-of-pocket maximum** applies separately to each covered person in the family. Once a family member reaches the individual **out-of-pocket maximum** shown in Your Plan at a Glance, the Plan pays 100% of that person's covered medical expenses for the rest of the **plan year**.

  In a family with more than two covered members, you may not have to meet the individual **out-of-pocket maximum** – see below for information about the family **out-of-pocket maximum**.

- The family **out-of-pocket maximum** applies to the family as a group of two or more members. When your family's combined out-of-pocket expenses satisfy the family **out-of-pocket maximum**, the Plan pays 100% of the family's covered medical charges for the remainder of the **plan year**.

Expenses are cross-applied to both the in-network and out-of-network **out-of-pocket maximum**s.

- Expenses that apply to the in-network **out-of-pocket maximum** apply toward the out-of-network **out-of-pocket maximum**.
- Expenses that apply to the out-of-network **out-of-pocket maximum** apply toward the in-network out-of-pocket maximum.

Certain expenses do ***not*** apply toward the **out-of-pocket maximum**:

- Expenses over the **recognized charge**; and
- Charges for services and supplies that are not covered by the Plan.
- Out-of-pocket costs incurred under the optional dental and vision plans.

The Medical Plan

How the Medical Plan Works

The COVA HealthAware Plan combines your medical benefits with a health reimbursement arrangement (HRA). Funds in your HRA will be used to pay your out-of-pocket costs for covered medical services. When your HRA is depleted, you pay any remaining out-of-pocket costs. If you don't use all of the money in your HRA by the end of the **plan year**, unused amounts can be rolled over to the following **plan year**, as long as you stay in the COVA HealthAware Plan.

Your COVA HealthAware HRA

1. **Your HRA is funded.**

   If you enroll in the COVA HealthAware Plan at the start of each **plan year**, your HRA will be funded per Plan provisions – refer to Your Plan at a Glance. If you enroll in the COVA HealthAware Plan after the start of the **plan year**, the basic contribution to your HRA will be prorated based on the number of months you will be enrolled for that year.

2. **The HRA fund is reduced by the out-of-pocket cost of your care.**

   As you incur out-of-pocket costs for covered medical, **prescription** drug and behavioral health care services and supplies, withdrawals are made automatically from your HRA fund to pay for them.

   The HRA fund can't be used for:

   - Any expenses over the Plan's limits for covered services;
   - Any expenses over the **recognized charge**, if you use **out-of-network provider**s;
   - Any out-of-pocket expenses for covered services under the optional expanded dental or optional expanded vision plans; or
   - Any expenses for services or supplies not covered by the Plan.

3. **After your HRA is exhausted, you must pay any further out-of-pocket expenses, such as meeting any remaining deductible.**

   When your HRA has a $0 balance, you then need to pay any remaining **plan year deductible** and **coinsurance** yourself.

Your HRA Can Grow

If you have money left in your HRA at the end of the **plan year**, it is rolled over to the next **plan year**, along with any new contributions per Plan provisions. There is no maximum limit to your HRA balance. Depending on your personal health needs, by spending carefully and making informed health care decisions, you can build savings for future health care expenses – as long as you stay in the COVA HealthAware Plan.

If You Leave the Plan With a Balance

If you leave the COVA HealthAware Plan with a balance in your HRA and you return within one year, your HRA balance will be reinstated, but no contributions will be made during the period that you were not in the COVA HealthAware Plan.

Earn Additional HRA Contributions by Completing "Do-Rights"

"Do-Rights" are actions you can take to promote good health. The following chart describes the "Do-Rights" that can result in additional HRA funding:

If you take this healthy action	You will earn this incentive credit toward your HRA	Who can earn this credit
Do-Right Incentives There are four Do-Right actions that earn incentive credits: • Have your routine physical exam • Have a routine dental exam • Get your flu shot • Use your My ActiveHealth Activity Tracker at least 3 times per month for each month in a quarter	$50 for each Do-Right action, up to a maximum of $150 per person	• Employee • Covered spouse

You can also earn HRA contributions by participating in the following health and wellness programs administered by ActiveHealth Management:

If you take this healthy action	You will earn this incentive credit toward your HRA	Who can earn this credit
"Healthy Beginnings" Maternity Program Incentive To earn the additional HRA credit: • Enroll in Healthy Beginnings, the ActiveHealth maternity program, in the first 16 weeks of your pregnancy; and • Complete the 28-week assessment.	$300 per person	• Employee • Covered spouse • Covered child
Bariatric Pre-Surgery Education Program To earn the HRA incentive, you must complete the 12 month ActiveHealth Healthy Insights Program.	$300 per person for inpatient surgery $150 per person for outpatient surgery	• Employee • Covered spouse • Covered child

The additional contribution will be automatically added to your HRA ***after*** you complete the healthy action/program, or when the service has been completed and the claim has been filed, whichever is applicable to the action. Once the funds are credited to your HRA fund, they will be applied toward your future out-of-pocket expenses. "Do-Right" contributions to your HRA will not be prorated, regardless of the date of enrollment or termination in the COVA HealthAware Plan during the **plan year**.

Any of the above incentives will be credited during the **plan year** in which it was earned (for example, the date of the action or completion of the program). However, no incentive credit will be available if is not reported within 90 days after the end of the **plan year** during which it was earned, Any incentive reported during this 90-day period will be credited to the previous **plan year** and then rolled over for use in the new **plan year**.

If a COVA HealthAware participant completes a "Do-Right" activity outside of the plan (for example, a covered spouse has a routine physical covered by another employer's health plan), have the claim filed for secondary coverage through COVA HealthAware so that the claim will trigger the "Do-Right" credit. If a participant gets a flu shot outside of the plan, your Benefits Administrator can provide you with a form to report the flu shot.

Questions?

You can learn more about the ActiveHealth Management Programs by logging in to **www.MyActiveHealth.com/COVA** or by talking to the Aetna Health Concierge at the toll-free telephone number shown on your Aetna ID card. More information is also available in the Resources, Tools and Programs and Health and Wellness Programs sections of this handbook.

New Hires and Qualifying Mid-Year Events

Your HRA may be affected by certain events that occur after July 1 each year. If you enroll as a new hire or have a qualifying mid-year event that allows you to enroll as an employee, your HRA fund amount will be prorated for the remainder of the **plan year**, based on the following schedule:

Effective Date of Your Enrollment or Status Change	Proration Percentage	HRA Adjustment per Employee and/or Spouse
July 1	100%	$600
August 1	92%	$552
September 1	83%	$498
October 1	75%	$450
November 1	67%	$402
December 1	58%	$348
January 1	50%	$300
February 1	42%	$252
March 1	33%	$198
April 1	25%	$150
May 1	17%	$102
June 1	8%	$48

If the employee leaves the Plan during the **plan year**, the HRA will not be decreased by a prorated amount, but the remaining balance can be used only for expenses incurred prior to the date of termination. Unused funds will be reinstated if the employee re-enrolls within one year.

Qualifying Mid-Year Event

If you have a qualifying mid-year event (QME) that allows you to add or remove a spouse:

- *Adding an eligible spouse after July 1 (the beginning of the **plan year**):* Your fund amount will increase by the prorated amount of the annual contribution based on the chart, above.
- *Removing your spouse after July 1:* Your fund amount will decrease by the prorated amount of the annual contribution, based on the chart, above. There is no penalty if you have used more than the new, reduced fund amount before the QME change, but you will have a zero fund balance for the remainder of the **plan year** unless you earn new "Do-Right" credits.
- In cases where two qualifying HRA funding events occur after the start of a **plan year**, proration of the HRA contribution (not including any incentive contributions) will reflect a weighting factor resulting in a slight difference from the chart. This could include an employee added after the start of the **plan year** followed by a later addition of a spouse, or an employee and spouse added after the start of the **plan year** followed by later termination of the spouse. For assistance with HRA proration, contact the Aetna Health Concierge at 855-414-1901.

Effect of Termination and Reinstatement on Your HRA

Termination

If you lose coverage in the COVA HealthAware Plan due to an Extended Coverage/COBRA qualifying event, you will have the opportunity to elect continuation coverage, including your HRA. For more information, refer to Continuing Coverage. If you do not elect continuation coverage, your HRA balance can be used only for expenses incurred prior to the date of coverage termination. Any remaining balance is forfeited. (Some exceptions may apply to retiring employees, employees transitioning to long-term disability or employees who are able to return to the COVA HealthAware Plan within one year.)

Plan Change

If you leave the COVA HealthAware Plan, any HRA balance will remain in your account for one year. You can use the balance for expenses incurred prior to the date you left the Plan.

- If you re-enroll in COVA HealthAware within one year, your balance will be carried over (no contribution during the period not enrolled) and contributions will be made going forward, per plan provisions.
- If you do not re-enroll in COVA HealthAware within one year, you will lose your fund balance.

Reinstatement

If you leave your job with the State, any HRA balance will remain in your account for one year. You can use the balance for expenses incurred prior to the date you left the Plan. If you then return and re-enroll in the COVA HealthAware Plan:

- *Within the same **plan year**:* Your remaining fund balance will be reinstated.
- *In a different **plan year**, but within 12 months of your termination date:* Your remaining fund balance will be reinstated.
- *In a different **plan year**, and more than 12 months from your termination date:* Your fund balance will be forfeited and you are treated as a new hire with a new fund, prorated based on your date of re-hire.

Retirement

If you are enrolled in the COVA HealthAware Plan at the time of retirement and you are eligible for, and enroll in, the State Retiree Health Benefits Program, you may:

- Continue participation in the COVA HealthAware Plan (if not eligible for Medicare), and HRA funding will continue per plan provisions.
- Enroll in a different plan in the State Retiree Health Benefits Program. If you enroll in a different non-Medicare-coordinating plan, but had an HRA balance at the time of your plan change, you will have one year to re-enroll in the COVA HealthAware Plan in order to reinstate your HRA balance (see Plan Change above).

If you become eligible for Medicare while enrolled in the COVA HealthAware Plan and maintain coverage in the State Retiree Health Benefits Program by electing a Medicare-coordinating plan, any remaining HRA funds will be available for reimbursement of premium costs within the state program for up to one year or until funds are exhausted. If you are not in the COVA HealthAware Plan when you become eligible for Medicare, you may use any remaining HRA balance within one year of originally leaving the COVA HealthAware Plan, as long as you remain enrolled in the State Program.

If you leave the State Retiree Health Benefits Program with an HRA fund balance, the balance can be used only for expenses incurred prior to the date of coverage termination. Any remaining balance is forfeited. (Covered family members may be eligible for Extended Coverage.)

If there are remaining funds at the time of retirement due to enrollment of your spouse, and you do not enroll your spouse in retiree or Extended Coverage, the amount of your HRA balance will be reduced by the prorated amount indicated on the previous chart. (Funding as the result of completing "Do-Rights" will not be prorated.)

Eligible claims by retirees for premium reimbursement must be submitted using a claim form. Forms are available at **www.covahealthaware.com** or by calling the Aetna Health Concierge.

Long-Term Disability

The HRA rules that apply to retirees also apply to long-term disability participants, except that any waiver periods will count against any one-year re-enrollment time limit.

Your Medical Plan Benefits

This chapter of your handbook provides detailed, benefit-specific information about what your Health Plan covers and what it does not cover. It expands upon the information provided in Your Plan at a Glance.

> ***Care Must Be Medically necessary***
>
> The Plan covers only services and supplies that are **medically necessary** to diagnose or treat an illness or injury. If a service or supply is not **medically necessary**, it will not be covered, even if it is listed as a covered expense in this handbook.

The Plan pays benefits for covered expenses only. Some expenses are not covered by the Plan. You'll find information about benefit-specific exclusions in this chapter. In addition, there are general exclusions that apply to all medical services. These are described in What the Medical Plan Does Not Cover.

Things to Consider as You Use Your Benefits

Primary Care

You are not required to choose a primary care **physician** (PCP) under the COVA HealthAware Plan. You and each covered member of your family have the option of selecting an internist, family care practitioner, general practitioner or pediatrician (for your children) to serve as your regular PCP. Regular **preventive care** is key to achieving good health, and a PCP can be your personal health care manager. He or she gets to know you and your special needs and problems, and can recommend a **specialist** when you need care that he or she can't provide. This can be very helpful, since you may not be comfortable choosing the right **specialist**.

> ***Share Information with Your PCP***
>
> You may wish to share information from your MyActiveHealth Personal Electronic Health Record with your PCP to help manage your care.

Precertification

Precertification is a process that helps you, your **physician** and other health care providers determine whether the medical services being recommended are covered expenses under the Plan. It also allows Aetna to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning).

Precertification starts with a telephone call to Aetna:

- If you use an **in-network provider**, your provider will make this call for you.
- If you intend to receive care from an **out-of-network provider**, you must make the call.

When You Should Precertify Care

To ensure services will be covered, you are responsible for getting **precertification** for the services in the following chart if your care will be given by an **out-of-network provider**. If you don't get **precertification** and Aetna later determines that the services are not covered, you will be responsible for 100% of the cost.

Remember!

Even if your services are covered, your **deductible** and **coinsurance** share generally will be higher when you use an **out-of-network provider**. Also, any costs over the **recognized charge** will be your responsibility and will not count toward your **out-of-pocket maximum**.

Type of Service	When You Need to Precertify Out-of-network care
Hospital Inpatient Care You should request **precertification** for inpatient confinement in an out-of-network **hospital**	To request **precertification**, call the Aetna Health Concierge at **1-855-414-1901** as follows: • **emergency admission**: within 48 hours of admission or as soon as reasonably possible • **urgent admission**: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission
Alternatives to Hospital Inpatient Care You should request **precertification** for the following **hospital** alternatives if your provider is not in the Aetna network: • skilled nursing facility care • home health care services • **hospice care** – inpatient and outpatient • private duty nursing	To request **precertification**, call the Aetna Health Concierge at **1-855-414-1901** as follows: • inpatient confinements: same as **hospital** inpatient care (above) • outpatient care: - non-**emergency care** – at least 14 calendar days in advance or as soon as reasonably possible - **emergency care** – as soon as reasonably possible
Inpatient Behavioral Health Care You should request **precertification** for inpatient confinement in an out-of-network **hospital**.	To request **precertification**, call the Health Concierge at **1-855-414-1901** or Aetna Behavioral Health at **1-800-424-4047** as follows: • **emergency admission**: within 48 hours of admission or as soon as reasonably possible • **urgent admission**: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission

Aetna will notify you, your **physician** and the facility about your precertified length of stay or treatment. If your **physician** recommends extension of your care, additional days should be certified to ensure coverage. You, your **physician** or the facility should call the Aetna Health Concierge no later than the final authorized day. Aetna will review and process the request for extended care. You, your **physician** and/or provider will receive a copy of this letter.

If You Don't Precertify

The **precertification** process lets you know ahead of time whether services are **medically necessary** and covered. There is no penalty if you do not get **precertification** and the services are **medically necessary** and covered. If, however, you do not get **precertification** for an out-of-network service, and Aetna later determines that the service is not **medically necessary** or covered, coverage will be denied.

Preventive Care

The Plan covers the preventive services listed below once per **plan year** (except as specifically indicated). Preventive services are covered at 100% if an **in-network provider** is used and 60% after the **deductible** if an **out-of-network provider** is used (except as specifically indicated).

Wellness Exams and Screenings

The Plan covers the following services for all participants (unless specifically indicated otherwise):

- Annual wellness check-up, including:
  - X-rays, laboratory services and other tests given in connection with the exam
  - Immunizations for infectious diseases and the materials needed to administer the immunizations
  - Testing for tuberculosis
- Colorectal cancer screening, including
  - One fecal occult blood test; and
  - One flexible sigmoidoscopy, or colonoscopy or double contrast barium enema
- Routine vision exam performed by an ophthalmologist or optometrist
- Routine hearing exam performed by an otolaryngologist or otologist or by an audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate or Clinical Competency in Audiology from the American Speech and Hearing Association; and
  - Performs the exam at the written direction of an otolaryngologist or otologist

As part of your routine wellness exam, the Plan covers the following, as appropriate for your age and gender:

- Cholesterol and lipid level screening
- Blood pressure
- Height, weight and body mass index (BMI)
- Screening for depression
- Diabetes screening
- Screening for sexually transmitted infections
- Human Immunodeficiency Virus (HIV) screening
- Bone density test to screen for osteoporosis
- Vitamin D test

Preventive Counseling and Education Intervention Services

The Plan covers charges made by a primary care **physician** for the following in an individual or group setting:

- Obesity screening and counseling services to help you lose weight if you are obese:
  - Unlimited visits up to age 22
  - Up to 26 visits per **plan year** for age 22 and older (healthy diet counseling limited to 10 visits)

  - Behavioral counseling to promote a healthy diet
- Primary care intervention to promote breastfeeding
- Counseling related to aspirin use, folic acid and iron for the prevention of cardiovascular disease (does not include coverage for aspirin, folic acid and iron)
- Screening and behavioral counseling related to helping you stop using tobacco products:
  - Up to 8 sessions per **plan year**
- Screening and behavioral counseling related to helping you control alcohol or other substance abuse
  - Up to 5 visits per **plan year**
- Human Immunodeficiency Virus (HIV) counseling
- Women's health counseling
  - Interpersonal and domestic violence
  - Sexually transmitted diseases (up to two occurrences per **plan year**)
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older
  - Genetic counseling and BRCA (breast cancer) testing
  - Counseling for women with a family history of ovarian cancer
  - Screening for gestational diabetes

Well-Child Visits

Frequency:

- From birth to 12 months – 7 exams
- Age 13-24 months – 3 exams
- Age 25-36 months – 3 exams
- Age 3 to 26 years – 1 exam per **plan year**

Preventive care for children up to 18 years old includes coverage for:

- Newborn screenings
- Vision screening
- Hearing screening
- Developmental and behavioral assessments
- Oral health assessment
- Screening for lead exposure

Preventive care for Women (no age limits)

The Plan covers:

- Gynecological examination
- Pap test
- Mammography screening
- Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, Chlamydia and HIV)

Preventive care for Men (no age limits)

The Plan covers:

- Prostate exam/digital rectal exam
- Prostate specific antigen test (PSA)
- Aortic aneurysm screening

Preventive care Immunizations

The Plan covers:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis - DTaP – (children under age 7)
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Haemophilus Influenza type b (Hib)
- Polio (up to age 18 only)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Rotavirus (up to age 18 only)
- Tetanus/Diphtheria/Pertussis – Tdap (adolescents and adults)
- Zoster/shingles (age 18 or older only)

Keep in Mind

The Plan does not cover immunizations that are needed only for travel or employment.

Limits

The following limitations apply to **preventive care**:

- Immunizations must be received in a provider's office or through the outpatient **pharmacy** benefit. (Routine immunizations are not covered in an outpatient **hospital** setting.
- Colorectal cancer screenings must be received in a provider's office or outpatient **hospital** setting. (Routine colorectal cancer screenings are not covered in an inpatient setting.)
- A diagnostic X-Ray or laboratory service performed in conjunction with a preventive exam and within 5 days before or after the exam are covered at 100% in network.
- If a preventive screening results in a diagnosis, the screening is not covered as **preventive care** and would be subject to the appropriate **deductible** and **coinsurance**.

Outpatient Care

The Outpatient services listed below are covered under your plan if:

- they are prescribed by a provider licensed to do so;
- all other conditions of coverage are met; and
- the care is determined to be **medically necessary**

Outpatient care is covered at 80% after the **deductible** if an **in-network provider** is used and 60% after the **deductible** if an **out-of-network provider** is used (unless specifically indicated otherwise).

Office Visits

The Plan covers **medically necessary** treatment by a doctor in his or her office, including allergy testing and treatment, behavioral health treatment, substance abuse treatment, supplies, radiology services, and tests given by the **physician**.

Walk-in clinics

A **walk-in clinic** is a free-standing health care facility. The Plan covers visits to **walk-in clinic**s for non-emergency treatment of an illness or injury, and for administration of certain immunizations.

> ***Keep in Mind***
>
> A **walk-in clinic** is a convenient, low cost alternative to visiting a doctor's office for minor medical problems such as colds, allergies and sprains. Many clinics offer extended business hours and are open in the evening. **Walk-in clinic**s do not provide ongoing **physician** care.

Outpatient Hospital Care

The Plan covers charges made by a **hospital** for services and supplies provided on an outpatient basis, including pre-admission testing and other diagnostic tests, therapy services, shots, **prescription** medications received during treatment, surgical services, , mammography, intensive outpatient services or **partial hospitalization** for behavioral health services, and routine colonoscopy screening.

Outpatient Surgery

The Plan covers outpatient surgery in:

- The office-based surgical facility of a **physician** or **dentist**;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery is covered only if it:

- Can be performed adequately and safely only in a **surgery center** or **hospital**; and
- Is not normally performed in a **physician**'s or **dentist**'s office.

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the **hospital**, **surgery center** or office-based surgical facility on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and the administration of anesthesia; and

- Services of another **physician** for related post-operative care and the administration of anesthesia (other than a local anesthetic). Assistant surgeon's services are covered if the operating surgeon explains to the claims administrator, upon request, why this surgical service requires the skills of two surgeons. Medical necessity is determined at the discretion of the claims administrator.

The Plan does ***not*** cover the services of a **physician** who renders technical assistance to the operating **physician.**

Oral Surgery

The Plan covers oral surgery and treatment of accidental injury to natural teeth. (In additional to outpatient care, **medically necessary** inpatient **hospital** services and supplies are covered.)

The plan covers:

- Services of a **physician** or **dentist** for treatment of the following conditions of the teeth, mouth, jaws, jaw joints or supporting tissues if **medically necessary**:
- Surgery necessary to treat a fracture, dislocation or wound;
- Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when **appliance** therapy alone cannot improve function;
- Surgery necessary to cut out cysts, tumors or other diseased tissues;
- Surgery needed to cut out:
- teeth partly or completely impacted in the bone of the jaw;
- teeth that will not erupt through the gum;
- other teeth that cannot be removed without cutting into bone; and
- the roots of a tooth without removing the entire tooth; or
- Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement or repair of teeth; and
- Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within the **plan year** of the accident, or in the following **plan year**. The teeth must have been free from decay or in good repair, and firmly attached to the jaw bone at the time of the injury.
  The Plan's coverage of **denture**s, **bridgework**, **crowns** and **appliance**s is limited to:
- The first **denture** or fixed **bridgework** to replace lost teeth;
- The first **crown** (cap) needed to repair each damaged tooth; and
- An in-mouth **appliance** used in the first course of **orthodontic treatment** after the injury.

Except as described above to treat accidental injury (or unless you are covered under the optional expanded dental coverage), the Plan does ***not*** cover charges:

- For in-mouth **appliance**s, **crowns**, **bridgework**, **dentures**, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For **root canal therapy**;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, **crowns**, **dentures** or **bridgework**;
- For non-surgical periodontal treatment;
- For dental cleaning, in-mouth **scaling**, planing or scraping; or

- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

> ***Keep in Mind***
> Oral surgery that requires an inpatient **hospital** confinement is covered when necessary and in accordance with the benefit description above.

Emergency Room Care

The Plan covers **emergency care** provided in a **hospital** emergency room or a free-standing emergency facility.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physician** services;
- **Hospital** nursing staff services;
- Radiology and pathology services; and
- Emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted.

If you are admitted to the **hospital** following emergency room treatment, remember that **hospital** admissions should be precertified to ensure coverage (see **Precertification** for details).

Urgent Care

The Plan covers the services of a **hospital** or urgent care provider to evaluate and treat an **urgent condition**. **Urgent care providers** are **physician**-staffed facilities offering unscheduled medical services.

The urgent care benefit covers:

- Use of urgent care facilities;
- **Physician** services;
- Nursing staff services; and
- The services of radiologists and pathologists.

Additional Covered Outpatient Services

The Plan also covers:

- Telemedicine
- Outpatient anesthesia services (includes acupuncture by a licensed provider in lieu of anesthesia)
- Second surgical opinion
- Diabetes outpatient self-management training and education performed in person; including medical nutrition therapy, when provided by a certified, licensed or registered health care professional. These services are only covered when billed by a medical provider or the outpatient department of a **hospital**. Diabetic education is covered at no cost to you.
- **Prescription** medications that require administration by a health professional including contraceptive devices and injections;
- The Plan covers inpatient or outpatient charges made by a **hospital** or a **physician** for the **medically necessary** surgical treatment of **morbid obesity**.

If you are seeking bariatric surgery, you are required to participate in a 12 –month ActiveHealth Management bariatric pre-surgery program. Your bariatric surgeon must contact Aetna's Provider Precertification to qualify for the program. For more information, see Health and Wellness Programs.

Coverage includes one **morbid obesity** surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat **morbid obesity**, unless a multistage procedure is planned.

Treatment must be by methods recognized by the National Institutes of Health (NIH) for patients who weigh at least 100 pounds over or twice the ideal body weight for frame, age, height and gender; have a body mass index equal to greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or have a body mass index of 40 kilograms per meter squared without such comorbidity.

The Plan also covers some services (such as abdominoplasties, panniculectomies and lipectomies) to correct deformity after gastric bypass surgery, other bariatric surgery procedures or other methods of weight loss.

- **Partial hospitalization** if **medically necessary**

Keep in Mind

- If two or more surgical services are performed during a single operative session, the Plan will only cover the primary surgical service plus a reduced amount for each additional surgical service instead of the amount that would have been paid had these services been performed alone.

Inpatient Care

Inpatient Hospital Care

The Plan covers **medically necessary** charges made by a **hospital** or **psychiatric hospital** for **room and board** when you are confined as prescribed by a licensed provider as an inpatient. **Room and board charges** are covered up to the **hospital**'s **semi-private room rate** due to **medically necessary** medical, surgical or behavioral health reasons**.**

Inpatient care is covered at 80% after the **deductible** if an **in-network provider** is used and 60% after the **deductible** if an **out-of-network provider** is used (unless specifically indicated otherwise).

The Plan also covers other services and supplies provided during your inpatient stay, such as:

- **Physician** and surgeon services; including services of an assistant surgeon if the operating surgeon explains to the Claims Administrator, upon request, why the skills of two surgeons are needed. If two or more surgeons provide a surgical service which could reasonably have been performed by one surgeon, the Plan will only pay for one surgeon.
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products;
- Radiation therapy;
- Physical, occupational and speech therapy;
- Cardiac and pulmonary rehabilitation;
- Oxygen and oxygen therapy;
- X-rays, laboratory tests and diagnostic services;
- Medications;
- Inpatient consultative services when requested by the attending **physician** (the consulting provider must examine you and enter a signed consultation note in your medical record);
- Intravenous (IV) preparations; and
- Discharge planning.

Keep in Mind

- The Plan does not cover private room charges that exceed the **hospital**'s **semi-private room rate** unless a private room is **medically necessary** because of a contagious illness or immune system problems.
- If a **hospital** does not itemize **room and board charges**, as well as other charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.
- Some **physician**s and other providers may bill you separately for services given during your **hospital** stay. If you receive services from a radiologist, anesthesiologist or pathologist who is not in the Aetna network (an **out-of-network provider**) during an inpatient stay at an in-network facility, the Plan will cover those services at the in-network benefit level. Services of other **out-of-network provider**s will be covered at the out-of-network benefit level, even if the **hospital** is an in-network **hospital**.
- If two or more surgical services are performed during a single operative session, the Plan will only cover the primary surgical service plus a reduced amount for each additional surgical

service instead of the amount that would have been paid had these services been performed alone.

Pre-Admission Testing

The Plan covers outpatient testing done by a **hospital**, **surgery center**, **physician** or licensed diagnostic lab before a covered surgical procedure, if the tests:

- Are related to surgery that will take place in a **hospital** or **surgery center**;
- Are completed within 14 days of your surgery;
- Are performed on an outpatient basis;
- Would be covered if you were confined in a **hospital**; and
- Are included in your medical record kept by the **hospital** or **surgery center** where the surgery takes place

The tests are covered only if they are not repeated in or by the **hospital** or **surgery center** where the surgery will take place.

Keep in Mind

If your tests indicate that surgery should not be performed because of your physical condition, the Plan covers the tests, but not the proposed surgery.

Surgery

The Plan covers the charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Keep in Mind

- You may need to have multiple surgical procedures done at the same time or during a single operating session. The Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).
  The Plan does ***not*** cover any surgery that is not **medically necessary**, even if performed with another procedure that is necessary.
- Pre-operative and post-operative visits by your surgeon are considered to be part of the surgical fee. The Plan does ***not*** cover separate fees for pre-operative and post-operative care.
- Surgery performed by a **physician** who is not in the Aetna network will be covered as **out-of-network care** and subject to **recognized charge** limits . . . even if the surgery is performed in an in-network **hospital**.

Anesthesia

The Plan covers the administration of anesthetics and oxygen by a **physician** (other than the operating **physician**) or Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

The Plan covers acupuncture services given by a **physician** as a form of anesthesia in connection with a covered surgical procedure.

Bariatric Surgery

The Plan covers inpatient or outpatient charges made by a **hospital** or a **physician** for the **medically necessary** surgical treatment of **morbid obesity**.

If you are seeking bariatric surgery, you are required to participate in a 12-month ActiveHealth Management bariatric pre-surgery program. Your bariatric surgeon must contact Aetna's Provider Precertification to qualify for the program. For more information, see Health and Wellness Programs.

Coverage includes one **morbid obesity** surgical procedure, including related outpatient services, within a two-year period that starts with the date of the first surgical procedure to treat **morbid obesity**, unless a multistage procedure is planned.

Treatment must be by methods recognized by the National Institutes of Health (NIH) for patients who weigh at least 100 pounds over or twice the ideal body weight for frame, age, height and gender; have a body mass index equal to greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or have a body mass index of 40 kilograms per meter squared without such comorbidity.

The Plan also covers some services (such as abdominoplasties, panniculectomies and lipectomies) to correct deformity after gastric bypass surgery, other bariatric surgery procedures or other methods of weight loss.

Keep in Mind

The Plan does not cover bariatric surgery when done for cosmetic reasons.

Oral Surgery

Oral Surgery that requires an inpatient **hospital** confinement is covered when **medically necessary** and includes the benefits described under Outpatient Care.

Reconstructive Surgery

The Plan covers reconstructive surgery if the surgery is needed:

- To improve a significant functional impairment of a body part.
- To repair an accidental injury that happens while you are covered by the Plan. The surgery must be performed within 24 months after the original injury. This time period may be extended for a child through age 18.
- To repair an accidental injury that occurred during a covered surgical procedure. The corrective surgery must be performed within 24 months after the original injury.
- To correct a severe anatomical defect present at birth (or appearing after birth) if the defect has caused:
  - Severe facial disfigurement; or
  - Significant functional impairment, and the purpose of the surgery is to improve function.
- As part of reconstruction following a mastectomy.

Transplants

If You Need a Transplant

Call the Health Concierge when you and your **physician** begin to discuss transplant services. Your Health Concierge can answer benefit questions, help you find an **in-network provider**, tell you about the services offered by the National Medical Excellence Program and refer you to the Special Case Customer Service Unit to start the transplant authorization process.

The Plan's transplant coverage includes (but is not limited to) the following transplants:

- Bone marrow/stem cell
- Heart
- Heart/lung
- Intestine
- Kidney
- Liver
- Lung
- Pancreas
- Simultaneous pancreas/kidney

In general, there are four phases in the transplant process:

- Pre-transplant evaluation and screening. This phase includes evaluation and acceptance into a transplant facility's transplant program.
- Pre-transplant candidacy screening. This phase includes compatibility testing of prospective organ donors who are immediate family members.
- Transplant event: This phase includes organ procurement, surgical procedures and medical therapies related to the transplant.
- Follow-up care. During this phase, you may need home health care services, home infusion services and other outpatient care.

A transplant coverage period begins at the point of evaluation for a transplant and ends on the later of:

- 180 days from the date of the transplant; or
- The date you are discharged from a **hospital** or outpatient facility for the admission or visit(s) related to the transplant.

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- The direct costs of obtaining the organ. Direct costs include surgery to remove the organ, organ preservation and transportation, and the hospitalization of a live donor, provided that the expenses are not covered by the donor's group or individual health plan.
- **Physician** or transplant team services for transplant expenses.
- **Hospital** inpatient and outpatient supplies and services, including:
  - Physical, speech and occupational therapy;
  - Biomedicals and immunosuppressants;
  - Home health care services; and
  - Home infusion services.
- Follow-up care.

As part of the transplant benefit, the Plan does ***not*** cover:

- Services and supplies provided to a donor when the recipient is not covered by this Plan;
- Outpatient drugs, including biomedicals and immunosuppressants, that are not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant coverage period ends;
- Harvesting or storage of organs without the expectation of an immediate transplant for an existing illness;
- Harvesting or storage of bone marrow, tissue or stem cells without the expectation of a transplant to treat an existing illness within 12 months; or
- Cornea or cartilage transplants unless otherwise preauthorized by Aetna.

Aetna offers a wide range of support services to those who need a transplant or other complex medical care. If you need a transplant, you or your **physician** should contact Aetna's National Medical Excellence Program® at **1-877-212-8811**. A nurse case manager will provide the support that you and your **physician** need to make informed decisions about your care.

Refer to Resources, Tools and Programs for more information about the National Medical Excellence Program.

The Institutes of Excellence™ Network

Through the Institutes of Excellence™ (IOE) network, you have access to a provider network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

The Plan covers the transplant as **in-network care** only when it is performed at an IOE facility. Transplants performed at any non-IOE facility are covered as **out-of-network care**, even if the facility is considered in-network for other types of care.

Alternatives to Hospital Inpatient Care

Services described in this section are covered at 80% after the **deductible** if an **in-network provider** is used and 60% after the **deductible** if an **out-of-network provider** is used (unless specifically indicated otherwise).

Skilled Nursing Facility

The Plan covers charges made by a **skilled nursing facility** during an inpatient stay, up to the maximum period of confinement, including:

- **Room and board charges**, up to the **semi-private room rate**. The Plan covers up to the private room rate if it is appropriate because of an infectious illness or a weak or compromised immune system.
- General nursing services.
- Use of special treatment rooms.
- Radiology services and lab work.
- Oxygen and other gas therapy.

To ensure that services are covered, contact the claims administrator prior to any non-**emergency admission** to determine that the services will be covered. Skilled nursing facility services that are determined not to be **medically necessary** will be denied for coverage.

Maximum Period of Confinement

The medical plan covers inpatient **hospital** expenses for up to 180 days per confinement. If you are discharged from the facility, then readmitted with less than a 90-day break between two admissions, the days allowable for the subsequent admission are reduced by the days used in the first. If there are more than 90 days between the two admissions, the days available for the subsequent admission start over for a full 180 days.

Home Health Care

The Plan covers professional, medically skilled services provided in your home when ordered by a **physician** and given to you under a **home health care plan** by a **home health care agency** while you are homebound up to 90 visits per **plan year**. Services must be approved by the Claims Administrator in advance of the service. Coverage includes:

- Part-time nursing care that requires the medical training of, and is given by, an **RN** or by an **LPN** under the supervision of an **RN**. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services, when provided in conjunction with, and in direct support of, care by an **RN** or **LPN**. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker, when provided in conjunction with, and in direct support of, care by an **RN**, **LPN** or licensed clinical social worker.
- Medical supplies, **prescription drugs** and lab services given by (or for) a **home health care agency**. Coverage is limited to what would have been covered if you had remained in a **hospital**.

Keep in Mind

- The Plan does not cover **custodial care**, even if the care is provided by a nursing professional, and family members or other caretakers cannot provide the necessary care.

- The Plan does not cover care that isn't part of a **home health care plan**.
- More than one approved visit per day will be counted as separate visits, but one visit by two or more health care workers will count as one visit unless different types of services are provided.
- Home health care visits are limited to 90 per **plan year**.

Hospice care

The Aetna Compassionate Care℠ Program offers support and services to those facing the advanced stages of an illness. Refer to Resources, Tools and Programs for more information.

The Plan covers **hospice care** for a person who is **terminally ill** (diagnosed with a terminal illness with a life expectancy of six months or less). **Hospice care programs** include palliative and supportive **physician**, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

The Plan covers:

- Charges made by a hospice facility, **hospital** or **skilled nursing facility** for:
  - Room and board and other services and supplies provided for pain control and other acute and chronic symptom management.
    The Plan covers charges for room and board up to the facility's **semi-private room rate**.
  - Services and supplies provided on an outpatient basis.
- Charges made by a licensed **hospice care agency** for:
  - Part-time or intermittent nursing care by an **RN** or **LPN** for up to eight hours in a day.
  - Part-time or intermittent home health aide services for up to eight hours in a day. These services consist mainly of caring for the patient.
  - Medical social services under a **physician**'s direction.
  - Psychological and dietary counseling.
  - Consultation or case management services provided by a **physician**.
  - Physical and occupational therapy.
  - Medical supplies.
- Charges made by providers who are not employed by the **hospice care agency**, as long as the agency retains responsibility 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.
    - part-time or intermittent home health aide services for up to eight hours in any one day.
    - medical supplies.
    - psychological or dietary counseling.
- Respite care to relieve primary caregivers.
- Bereavement counseling.

The Plan's **hospice care** benefit does ***not*** include coverage for:

- Private or special nursing services.

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling, including estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services not entirely related to the care of a patient and include sitter or **companion** services for the patient or other family members, transportation, housecleaning and home maintenance.

Private Duty Nursing

The Plan covers charges made by a Registered Nurse (**RN**) or Licensed Practical Nurse (**LPN**) for private duty nursing if a person's condition requires **skilled nursing services** and visiting nursing care is not enough. Services must be **medically necessary** for the participant's condition and not merely custodial in nature. Services are not covered if provided by a family member.

The Plan also covers skilled observation following:

- A change in your medication;
- Treatment of an emergency or urgent medical condition;
- The onset of symptoms that indicate the need for emergency treatment;
- Surgery; or
- A **hospital** stay.

Coverage for skilled observation is limited to one four-hour period per day, for up to 10 days.

The Plan does ***not*** cover:

- Any care that does not require the education, training and technical skills of an **RN** or **LPN**. This would include transportation, meal preparation, charting of vital signs and **companion**ship activities.
- Any private duty nursing care provided on an inpatient basis.
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.
- Nursing care that consists only of skilled observation, except as described above.
- Any service provided only to administer oral medicines, except where the law requires medication to be administered by an **RN** or **LPN**.

Other Covered Services

Services described in this section are covered at 80% after the **deductible** if an **in-network provider** is used and 60% after the **deductible** if an **out-of-network provider** is used (unless specifically indicated otherwise).

Ambulance

The Plan covers charges made for a professional **ambulance**. The conditions for coverage vary with the type of vehicle used:

*Ground **Ambulance***

The Plan covers:

- Transportation in a medical emergency to the first **hospital** where treatment is given;
- Transportation in a medical emergency from one **hospital** to another **hospital** when the first **hospital** does not have the required services or facilities for your condition;
- Transportation from **hospital** to home or to another facility when an **ambulance** is **medically necessary** for safe and adequate transport; and
- Transportation while confined in a **hospital** or skilled nursing facility to receive **medically necessary** inpatient or outpatient treatment when an **ambulance** is required for safe and adequate transport.

*Air or Water **Ambulance***

In a medical emergency, transport by air or water **ambulance** to the **hospital** is covered. Coverage is also provided from one **hospital** to another **hospital** if:

- The first **hospital** does not have the required services or facilities for your condition; and
- Ground **ambulance** is not medically appropriate because of the distance, or your condition is unstable and requires medical supervision and rapid transport.

Applied Behavior Analysis/Habilitation Therapy Services

The Plan covers Applied Behavior Analysis (ABA) for treatment of Autism Spectrum Disorder (ASD) from age two through age six. This includes any pervasive developmental disorder, including Autistic Disorder, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder or Pervasive Development Disorder.

ABA is an educational component of ASD which may include the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. It must conform to the process of applying interventions that are based on the principles of learning derived from experimental psychology research to systematically change behavior and to demonstrate that the interventions used are responsible for the observable improvement in behavior. ABA methods are used to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations.

ABA services for treatment of a participant diagnosed with ASD must be defined in a treatment plan from a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**. In addition, the service must be provided or supervised by a Behavior Analyst Certifying Board (BACB) certified behavior analyst who is licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of ABA.

What is the Difference Between Habilitation Therapy and Rehabilitation Therapy?

- Habilitation therapy focuses on developing function that did not previously exist due to developmental delay. It is typically long-term.
- Rehabilitative services are short-term in nature and focus on restoring function that was lost due to injury, illness or a surgical procedure.

Chemotherapy

Coverage for chemotherapy depends on where you receive treatment:

- In most cases, chemotherapy is covered as outpatient care.
- The plan covers the initial dose of chemotherapy given in the **hospital** when:
  - You have been hospitalized for the diagnosis of cancer; and
  - A **hospital** stay is necessary based on your health status.

Chiropractic Care

The Plan covers manipulative treatment of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a **physician** or licensed chiropractor in the provider's office. Treatment before or after surgery is not covered as a spinal manipulation benefit.

Spinal manipulations and other manual medical interventions and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations are eligible for coverage related to biomechanics or serve conduction disorders of the spine. Care must be given by a **physician** or licensed chiropractor in the provider's office. Treatment before or after surgery is not covered as a spinal manipulation benefit. These services are most commonly performed by a chiropractor, general practitioner, physical therapist or osteopath. These services are limited to 30 visits per member per **plan year**.

Clinical Trial Costs

The Plan covers patient costs incurred during participation in a clinical trial when such trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

- Coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer. Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.
- Treatment provided by a clinical trial is approved by:
  - The National Cancer Institute (NCI):
  - An NCI cooperative group or an NCI center;
  - The US Food and Drug Administration in the form of an investigational new drug application;
  - The Federal Department of Veterans Affairs; or
  - An institutional review board of an institution in the Commonwealth of Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.
- With respect to the treatment provided by a clinical trial:
  - There is no clearly superior, non-investigational treatment alternative;

  - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and
  - The covered person and the **physician** or health care provider who provides the services to the covered person conclude that the covered person's participation in the clinical trial would be appropriate
- The Facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.
- All of the following conditions must be met:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food and Drug Administration or the Department of Defense) and conforms to NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and

Patient cost means the cost of **medically necessary** health care service that is incurred as a result of the treatment being provided to the covered person for purposes of a clinical trial. It does not include the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, costs associated with managing the research associated with the clinical trial, or the cost of the investigational drug or device.

Diabetic Equipment, Supplies and Education

The Plan covers the following services and supplies used in the treatment of insulin and non-insulin dependent diabetes and elevated blood glucose levels during pregnancy:

- External insulin pumps and supplies;
- Foot care to minimize the risk of infection;
- Lancet devices;
- Calibration solution;
- Glucagon emergency kits; and
- Self-management training provided by a licensed health care provider who is certified in diabetes self-management training.

Diagnostic Complex Imaging

The Plan covers complex imaging services to diagnose an illness or injury, including:

- Computerized axial tomography (CAT) scans;
- Magnetic Resonance Imaging (MRI); and
- Positron Emission Tomography (PET) scans.

Diagnostic X-Ray and Laboratory (DXL) Procedures

The Plan covers necessary x-rays, laboratory services and pathology tests to diagnose an illness or injury.

Reminder

It's important to use **in-network provider**s to keep your share of the cost as low as possible. Before going to an outpatient facility for complex imaging services, make sure that the facility is in the network. Tests done by an out-of-network facility will be covered as **out-of-network care**, even if your tests were ordered by an in-network **physician**.

Durable Medical and Surgical Equipment and Supplies

The Plan covers the rental of durable medical and surgical equipment. Examples include wheelchairs, crutches, **hospital** beds, nebulizers, traction equipment, walkers, CPAP and oxygen for home use. The Plan covers only one item for the same (or a similar) purpose, plus the accessories needed to operate the item.

Instead of rental, the Plan may cover the purchase of equipment if:

- It either can't be rented or would cost less to purchase then to rent; and
- Long-term use is planned.

The Plan also covers the repair of this equipment when necessary. Maintenance and repairs needed because of misuse or abuse of the equipment are not covered.

Replacement is covered if you show Aetna that the repair is needed because of a change in the person's physical condition, or if it is likely to cost less to purchase a replacement than to repair existing equipment or rent similar equipment.

The Plan also covers fitting, adjustment, and repair of the following items when prescribed by your doctor for Activities of Daily Living:

- Artificial limbs, including accessories;
- Orthopedic braces;
- Leg braces, including attached or built-up shoes attached to the leg brace;
- Arm braces, back braces and neck braces;
- Head halters;
- Catheters and related supplies;
- Orthotics, other than foot orthotics;
- Splints;
- Breast prostheses; and
- Wigs.

Certain Prescribed Eyeglasses or Contact Lenses

The following prescribed eyeglasses or contact lenses are covered only when required as a result of surgery or for treatment of accidental injury:

- Eyeglasses or contact lenses which replace human lenses lost as the result of intra-ocular surgery or accidental injury to the eye;
- "Pinhole" glasses used after surgery for a detached retina; or
- Lenses used instead of surgery, such as:
  - Contact lenses for the treatment of infantile glaucoma;
  - Corneal or scleral lenses in connection with keratoconus;
  - Sclera lenses to retain moisture when normal tearing is not possible or is not adequate; or
  - Corneal or scleral lenses to reduce a corneal irregularity (other than astigmatism)

A maximum of one set of eyeglasses or one set of contact lenses will be covered for your original **prescription** or for any change in your original **prescription**. Examination and replacement for a **prescription** change are covered only when the change is due to the condition for which you needed the original **prescription**.

Early Intervention Services

Early intervention services are for covered family members from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (DBHDS) as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA). You are responsible for contacting your local DBHDS agency to initiate certification. Services are designed to help an individual attain or retain the capability to function age-appropriately within his or her environment. This shall include services which enhance functional ability without affecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not **medically necessary**.

These services consist of:

- Speech and language therapy;
- Occupational therapy;
- Physical therapy; and
- Assistive technology services and devices; for example, hearing aids, glasses and **durable medical equipment**.

Physical, occupational or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal is only available for children under age 3 who qualify for early intervention services.

Prosthetic Devices

The Plan covers internal and external prosthetic devices and special **appliance**s. The device or **appliance** must improve or restore the function of a body part lost or damaged by illness, injury or congenital defect.

Coverage includes:

- Purchase of the first prosthesis that you need to temporarily or permanently replace an internal body part or organ, or an external body part.
- Instruction and incidental supplies needed to use a covered prosthetic device.
- Replacement of a prosthetic device if:
  - The replacement is needed because of a change in your physical condition or because of normal growth or wear and tear;
  - Replacement is likely to cost less than repairing the existing device; or
  - The existing device cannot be made serviceable.
- Coverage for up to three wigs per **plan year**

Radiation Therapy

The Plan covers the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Radiology Services

The Plan covers radiology services provided by a **physician**, **hospital** or licensed radiology facility or lab to diagnose an illness or injury.

Special Medical Formulas

Special medical formulas are covered only if they are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a **physician** and required to maintain adequate nutritional status.

Voluntary Sterilization

The Plan covers charges made by a **physician** or **hospital** for:

- Vasectomy;
- Tubal ligation; and
- Reversal of a sterilization procedure.

Contraception Services

The Plan covers the following contraceptive services and supplies when obtained from, and billed by, your **physician**:

- Contraceptive counseling.
- Contraceptive devices prescribed by a **physician**.
- Office visit for the injection of injectable contraceptives.
- Related outpatient services such as consultations, exams and procedures.

Your Plan at a Glance provides specific benefit levels for these services. Other contraceptives may be covered as part of the Plan's **prescription** drug coverage. Refer to the section of this book describing **Prescription** Drug Coverage for more information.

Infertility Services

The Plan covers the diagnosis and treatment of the underlying cause of **infertility**, including:

- Initial evaluation, including history, physical exam and laboratory studies performed at an appropriate laboratory;
- Evaluation of ovulatory function;
- Ultrasound of ovaries at an appropriate participating radiology facility;
- Post-coital test;
- Hysterosalpingogram;
- Endometrial biopsy; and
- Hysteroscopy.

Infertility *Service Exclusions*

The Plan does ***not*** cover:

- Advanced reproductive therapies, including IVF, GIFT, ZIFT, cryopreserved embryo transfers, ICSI and ovum microsurgery;
- Ovulation induction;
- Intrauterine insemination;
- Purchase of donor sperm;

- Storage of sperm;
- Purchase of donor eggs;
- Care of the donor required for donor egg retrievals or transfers;
- Cryopreservation or storage of cryopreserved eggs or embryos;
- All charges associated with gestational carrier programs, for either the covered person or the gestational carrier;
- Home ovulation prediction kits;
- **Infertility** services for covered females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- **Infertility** services that are not reasonably likely to be successful;
- Services received by a spouse or partner who is not covered by the Plan; or
- Services and supplies obtained without the necessary referrals or claim authorization from Aetna's **Infertility** Case Management Unit.

Maternity Care

The Plan covers prenatal, delivery and postnatal maternity care. In accordance with the Newborns' and Mothers' Health Protection Act, the Plan covers inpatient care of the mother and newborn child for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.

If you and your attending **physician** agree to an earlier discharge from the **hospital**, the Plan will pay for one post-delivery home visit by a health care provider.

Maternity services include:

- Routine delivery services (Cesarean birth is a surgical service);
- Anesthesia services to provide complete or partial loss of sensation before delivery;
- Services for complications of pregnancy;
- Services for miscarriage; and
- Services for the care of a newborn child if the child is an eligible family member at the time services are rendered such as:
  - Initial examination of a newborn and circumcision of a covered male dependent
  - **Hospital** services for non-routine nursery care for the newborn should complications arise that require the newborn to be admitted
  - Fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies

Precertification is not required for the first 48 hours of **hospital** confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits should be precertified to ensure coverage. You, your doctor or another health care provider can request **precertification** by calling the Aetna Health Plan Concierge.

> ***Keep in Mind***
>
> The Plan does not cover home births. This is childbirth that takes place outside a **hospital** or birthing center, or in a place that is not licensed to perform deliveries.

Birthing Center

The Plan covers prenatal, delivery and postnatal maternity care provided by a birthing center. Postnatal care must be given within 48 hours after a vaginal delivery, or 96 hours after a cesarean section.

Breast Feeding Support, Counseling and Supplies

The Plan covers:

- Breast feeding assistance, training and counseling services by a certified lactation support provider in a group or individual setting.
- Initial purchase of a standard (not **hospital**-grade) electric breast pump or manual breast pump during pregnancy or while breast feeding.
- Purchase of the accessories needed to operate the breast pump.
- For each subsequent pregnancy:
  - Purchase of a replacement manual breast pump.
  - Purchase of a replacement standard electric breast pump, if:
    - you have not purchased a standard electric pump within the past three years; or
    - the initial electric pump is broken or out of warranty.
  - Purchase of a new set of breast pump supplies.

Your Plan at a Glance provides specific benefit information regarding these services and supplies.

Therapy Services

The Plan covers the following therapy services when treatment is prescribed by a **physician**, is determined to be **medically necessary**, and is provided by a licensed or certified physical, occupational or speech therapist, **home health care agency** or a **physician**.

- Outpatient cardiac rehabilitation (the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease) following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The services must be part of a treatment plan based on your risk level and recommended by your **physician**. The Plan covers up to 36 sessions in a 12-week period.
- Outpatient pulmonary rehabilitation to treat reversible pulmonary disease. The Plan covers up to 36 hours or a six-week period of therapy.
- Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents
- Infusion/IV therapy (treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients) Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.
- Occupational therapy (treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing)
- Physical therapy (treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, surgery or loss of limb). Your coverage includes benefits for physical therapy to treat lymphedema.
- Cognitive therapy associated with physical rehabilitation when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

- Radiation therapy, including the rental or cost of radioactive materials. This includes treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
- Respiratory therapy (the introduction of dry or moist gases into the lungs to treatment illness or injury)
- Speech therapy (treatment for the correction for a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment) Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty of expressing one's thoughts with spoken words.

Therapy should follow a specific treatment plan that details the treatment and specifies frequency and duration; provides for ongoing reviews and is renewed only if continued therapy is appropriate; and, allows therapy services provided in your home if you are homebound.

Experimental and investigational

In general, the Plan does ***not*** cover drugs, devices, treatments or procedures that are **experimental and investigational**. There are, however, some situations where the Plan will cover a drug, device, treatment or procedure that would otherwise be considered **experimental and investigational**.

The Plan will cover care that is considered **experimental and investigational** if the care meets ***all*** the following conditions:

- You have been diagnosed with cancer or a condition likely to cause death within one year;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an institutional review board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the U.S. Food and Drug Administration or the Department of Defense) and conforms to NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
- You are treated in accordance with protocol.

What the Medical Plan Does Not Cover

The Plan does not cover all medical expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive. Just because a type of medical treatment or an expense is not listed here does not mean that the treatment or expense will be covered by the Plan.

General Exclusions

The Plan does ***not*** cover charges:

- For any item or service that is primarily for the personal comfort and convenience of you or a third party.
- For cancelled or missed appointments.
- For care, treatment, services or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider's license.
- For care, treatment, services or supplies not prescribed, recommended or approved by a **physician** or **dentist**.
- For claim form completion.
- For services and supplies Aetna determines are not **medically necessary** for the diagnosis, care or treatment of the disease or injury involved – even if they are prescribed, recommended or approved by a **physician** or **dentist**.
- For services given by volunteers or persons who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in school, college or camp infirmaries.
- For services of a resident **physician** or intern.
- For services, supplies, medical care or treatment given by members of your immediate family (your spouse, child, step-child, brother, sister, in-law, parent or grandparent) or your household.
- Incurred before the date coverage starts or after the date coverage ends.
- In excess of the **recognized charge** for a service or supply given by an **out-of-network provider**.
- In excess of the **negotiated charge** for a given service or supply given by an **in-network provider**.
- Made only because you have health coverage or that you are not legally obligated to pay, such as:
  - Care in charitable institutions; or
  - Care in a **hospital** or other facility that is owned or operated by any government, except to the extent coverage is required by law.
- Related to employment or self-employment. This includes injuries or illnesses that arise out of (or in the course of) any work for pay or profit, unless there is no other source of coverage or reimbursement available to you.
- To have preferred access to a **physician**'s services, such as boutique or concierge **physician** practices.
- Nutritional support administered orally unless specifically listed as a covered supply.
- **Ambulance** transport for convenience or other transport that is not **medically necessary**.

Alternative Health Care

The Plan does ***not*** cover charges for:

- Acupuncture, acupuncture therapy and acupressure, except when performed by a **physician** as a form of anesthesia for surgery covered by the Plan.
- Alternative or non-standard allergy services and supplies, including (but not limited to):
  - Cytotoxicity testing (Bryan's Test);
  - Skin titration (Rinkel method);
  - Treatment of non-specific candida sensitivity; and
  - Urine autoinjections.
- Aromatherapy.
- Bioenergetic therapy.
- Carbon dioxide therapy.
- Herbal medicine.
- Massage therapy.
- Megavitamin therapy.
- Rolfing.
- Thermography and thermograms.

Behavioral Health Care

The Plan does ***not*** cover charges for:

- Administrative psychiatric services when these are the only services rendered.
- Biofeedback.
- Confrontation therapy.
- Consultations with a behavioral health professional for adjudication of marital, child support and custody cases.
- Court-mandated or legally mandated treatment that is not considered **medically necessary**, as determined by Aetna, or that would not otherwise be covered by the Plan.
- Ecological or environmental medicine, diagnosis or treatment.
- Educational evaluation/remediation therapy or school consultations.
- Erhard Seminar Training (EST) or similar motivational services.
- Expressive therapies (art, poetry, movement, psychodrama).
- Hypnosis and hypnotherapy.
- Lovaas therapy.
- Marriage, family, child, career, social adjustment, religious, pastoral or financial counseling.
- Mental and psychoneurotic disorders not listed in the International Classification of Diseases, Ninth Revision (ICD-9).
- Behavioral health treatment for weight reduction or control, except a psychological evaluation required in preparation for bariatric (weight loss) surgery.
- Primal therapy.
- Psychological counseling related to changing sex or sexual characteristics.
- Psychodrama.
- Services provided by a residential treatment facility.

- Services that are not considered **effective treatment of alcohol or substance abuse** or **effective treatment of a mental disorder**.
- Stand-by services required by a **physician**.
- Therapies for the treatment of delays in development, unless resulting from acute illness or injury or congenital defects that are amenable to surgical repair (such as cleft lip or palate), or as described in Outpatient Habilitation Therapy Services.
- Transcendental meditation.
- Treatment of antisocial personality disorder.
- Treatment of health care providers who specialize in behavioral health and receive treatment as part of their training in that field.
- Treatment of impulse control disorders such as:
  - Caffeine use;
  - Kleptomania;
  - Pathological gambling; or
  - Pedophilia.
- Treatment of intellectual disabilities, defects and deficiencies. This exclusion does not apply to behavioral health services or to medical treatment for someone who is intellectually incapacitated.
- Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-IV diagnosis.
- Wilderness programs.

Note: Some services excluded from medical plan coverage may be available through the Employee Assistance Program.

Biological and Bionic

The Plan does ***not*** cover charges for:

- Blood, blood plasma, synthetic blood, blood products or blood substitutes, including (but not limited to) the provision of blood, other than blood derived clotting factors. The Plan does not cover any related services, including:
  - Processing, storage or replacement costs; or
  - The services of blood donors, apheresis or plasmapheresis.

  For autologous blood donations, only administration and processing costs are covered.
- Growth hormones, surgical procedures or any other treatment, device, drug, service or supply used solely to increase or decrease height or alter the rate of growth.

Cosmetic Procedures

The Plan does ***not*** cover the following, regardless of whether the service is provided for psychological or emotional reasons:

- Plastic surgery;
- Reconstructive surgery, except as described under Reconstructive Surgery;
- Cosmetic surgery; or
- Other services, treatments or supplies that improve, alter or enhance the shape or appearance of the body.

Custodial and Protective Care

The Plan does ***not*** cover charges for:

- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- Care, services and supplies provided in a:
  - Rest home;
  - Assisted living facility;
  - Health resort, spa or sanitarium; or
  - Similar institution serving as an individual's primary residence or providing primarily custodial or rest care.
- **Custodial care –** care provided to help a person in the activities of daily life.
- Maintenance care.
- Removal from your home, work place or other environment of potential sources of allergy or illness, including asbestos, fiberglass, dust, mold and paint.

Basic/Preventive Dental Care

The Plan does ***not*** cover services, treatment or supplies related to the care, filling, removal or replacement of teeth (basic restorative/primary and complex restorative/major services), including:

- Apicoectomy (dental root resection), **root canal therapy**, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty.
- Application of **fluoride** and other substances to protect, clean or alter the appearance of teeth except for those under age 19 (limit of two treatments per **plan year**).
- Dental implants, false teeth, plates, **dentures**, braces, mouth guards or other devices to protect, replace or reposition teeth.
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including:
  - Treatment of malocclusion; and
  - Devices to alter bite or alignment.

Note: Some services excluded from medical plan coverage may be covered under the optional expanded dental plan.

Education and Training

The Plan does ***not*** cover charges for:

- Services or supplies related to education, training, retraining services or testing, including:
  - Special education;
  - Remedial education;
  - Job training; or
  - Job hardening programs.
- Except as described in Outpatient Habilitation Therapy Services, evaluation, training, cognitive rehabilitation or treatment, regardless of the underlying cause, of:
  - Learning disabilities;
  - Minimal brain dysfunction;
  - Developmental, learning and communication disorders; and
  - Behavioral disorders, including pervasive developmental disorders.

- Except as described in Outpatient Habilitation Therapy Services, services, treatment, and education testing or training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Experimental and investigational

In general, the Plan does ***not*** cover drugs, devices, treatments or procedures that are **experimental and investigational**. There are, however, some situations where the Plan will cover a drug, device, treatment or procedure that would otherwise be considered **experimental and investigational**. See Other Covered Services for more information regarding requirements for coverage.

Other Services - Maternity

The Plan does ***not*** cover:

- Home uterine activity monitoring.
- Home Births
- Voluntary abortion, except when:
  - **Medically necessary** to save the life of the mother;
  - The pregnancy occurs as the result of rape or incest that has been reported to the law enforcement or public health agency; or
  - The fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency that is certified by a **physician**.

Foot Care

The Plan does ***not*** cover services, supplies or devices to improve the comfort or appearance of toes, feet or ankles, including:

- Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, or other equipment, devices or supplies, even when required after treatment of an illness or injury that was covered by the Plan.
- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet or chronic foot pain.
- Treatment for conditions caused by routine activities such as walking, running, working or wearing shoes.

Government and Armed Forces

The Plan does ***not*** cover charges – to the extent allowed by law – for services or supplies provided, paid for, or for which benefits are provided or required:

- Because of a person's past or present service in the armed forces of a government.
- Under any government law.

Health Exams

The Plan covers exams that are **necessary** to treat illness or injury, and routine preventive exams as described in the **Preventive care** section. The Plan does ***not*** cover exams or related reports (including report presentation and preparation) required:

- By any government law.
- By a third party, including exams to obtain or maintain employment, or which an employer must provide under a labor agreement.
- To obtain professional or other licenses or to obtain insurance.

- To travel; attend a school, camp or sporting event; or participate in a sport or other recreational activity.

Home and Mobility

The Plan does ***not*** cover:

- Alterations or additions to your home, work place or other environment, or any related equipment or device, including (but not limited to):
  - Bathroom equipment such as tub seats, benches, rails and lifts.
  - Equipment or supplies to help you sit or sleep, such as electric beds, water beds, air beds, warming or cooling devices, elevating chairs and reclining chairs.
  - Exercise and training devices, whirlpools, sauna baths, massage devices or over-bed tables.
  - Purchase or rental of air purifiers, air conditioners, water purifiers or swimming pools.
  - Room additions or changes to countertops, doorways, lighting, wiring or furniture.
  - Stair glides, wheelchair ramps and elevators.
- Vehicles and transportation devices, or alterations to any vehicle or transportation device.

Family Planning and Reproductive Health

The Plan does ***not*** cover charges for:

- Drugs to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy, whether delivered in oral, injectable or topical forms, even if they are used for another indication. This exclusion applies whether or not the drug is delivered in oral, injectable or topical forms (including but not limited to creams, ointments and patches).
- Over-the-counter contraceptive supplies, including (but not limited to) condoms and contraceptive foams, jellies and ointments. (However, these may be covered under the **prescription** drug plan.)
- Therapy, supplies or counseling for sexual dysfunction or inadequacies with no physiological or organic basis.
- Treatment, drugs, services or supplies related to changing sex or sexual characteristics, including:
  - Surgical procedures to alter the function or appearance of the body;
  - Hormones or hormone therapy;
  - Prosthetic devices; and
  - Medical or psychological counseling.
- Treatment, drugs, services or supplies to treat sexual dysfunction, enhance sexual performance or enhance sexual desire, including:
  - Surgery, drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sexual organ; and
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Therapy and Habilitation Services

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy, Speech Therapy and Applied Behavior Analysis

Unless specified in What the Medical Plan Covers, the Plan does ***not*** cover:

- Educational services;
- Any services unless provided in accordance with a specific treatment plan;

- Any services that are covered expenses in whole or in part under any other group health plan sponsored by an employer;
- Services provided during a stay in a **hospital**, skilled nursing facility or hospice facility except as stated in What the Medical Plan Covers;
- Services provided by a **home health care agency**;
- Services not performed by a **physician**, occupational, speech or physical therapist, or a practitioner certified by the Behavior Analyst Certifying Board (BACB) or under the direct supervision of a **physician**;
- Services provided by a **physician** or physical, occupational or speech therapist, or a practitioner certified by the Behavior Analyst Certifying Board (BACB) who resides in your home or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
- Special education to instruct a person to function. This includes lessons in sign language.

Strength and Performance

The Plan does not cover services, devices and supplies to enhance your strength, physical condition, endurance or physical performance, including:

- Drugs or preparations to enhance strength, performance or endurance.
- Exercise equipment.
- Lifestyle enhancement drugs or supplies.
- Memberships in health or fitness clubs.
- Training, advice or coaching.
- Treatments, services and supplies to treat illness, injury or disability related to the use of performance-enhancing drugs or preparations.

Tests and Therapies

The Plan does ***not*** cover charges for:

- Full-body CAT scans.
- Hair analysis.
- Hyperbaric therapy, except to treat decompression or promote healing of a wound.
- Sleep therapy that is considered experimental or investigational.

Vision and Hearing

The medical plan does ***not*** cover charges for:

- Eyeglass lenses, frames or contact lenses, including:
  - Anti-reflective coatings and tinting of eyeglass lenses.
  - Duplicate or spare glasses, lenses or frames.
  - Fitting of glasses or contact lenses for any purpose other than after cataract surgery.
  - Replacement of lenses or frames that are lost, stolen or broken.
- Eye surgery to correct vision, including radial keratotomy, LASIK and similar procedures.
- Hearing aids and their fitting, and hearing aid therapy or training.
- Special services, such as non-**prescription** sunglasses and subnormal vision aids.
- Vision services mainly to correct refractive errors.
- Visual perceptual training.

> ***Keep in Mind***
>
> The Plan's Optional Expanded Vision Plan covers eyewear. Refer to The Optional Expanded Vision Plan for more information.

Weight Control Services

Regardless of the existence of comorbid conditions, the Plan does not cover charges for weight control, except as described in **Preventive care**, Preventive Counseling and Education Intervention Services and Bariatric Surgery. The Plan does ***not*** cover charges for:

- Weight control/loss programs;
- Dietary regimens and supplements;
- Appetite suppressants and other medications;
- Food or food supplements; or
- Exercise programs or equipment.

> ***Keep in Mind***
>
> The Healthy Lifestyles coaching program can help with weight management.

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Prescription Drug

Coverage for **prescription drugs** is an important part of your health care coverage. The medical plan covers **prescription drugs** that are to be taken on an outpatient basis.

Drugs that you need while you are confined in a **hospital** or other covered health care facility may be covered as part of your inpatient benefit – refer to the sections of this book that describe inpatient benefits for more information.

You have two ways to fill a **prescription**:

- At a retail **pharmacy**; or
- By mail order, through Aetna Rx Home Delivery.

Generic and Brand-name drugs

To save money, consider using **generic drugs**. **Generic drug**s are approved by the U.S. Food and Drug Administration, which means that a **generic drug** has the same quality, strength and effectiveness as the brand-name equivalent. You can ask your doctor to prescribe a **generic drug** or ask your pharmacist if there is a **generic drug** that is equal to the brand name drug your doctor prescribed.

> ***Keep in Mind***
>
> If you or your doctor request a **brand-name drug** when a **generic drug** is available, you will be responsible for the difference between the cost of the **brand-name drug** and the cost of the **generic drug**, in addition to the medical plan's **deductible** and **coinsurance**. The difference in cost that you pay does ***not*** apply to the medical plan's **out-of-pocket maximum** if the request for the brand-name drug was not made by the prescribing physician.

Retail Pharmacy

In-network pharmacy

You may fill your **prescription** for up to a 90-day supply at a **pharmacy** that belongs to Aetna's **pharmacy** network. Show your ID card and pay the **deductible** and/or **coinsurance** shown in Your Plan at a Glance at the time of your purchase. There are no claim forms to fill out.

You can find a list of in-network pharmacies using DocFind at **www.aetna.com**. You can also call the Health Concierge who can help you find an **in-network pharmacy** in your area.

Out-of-Network Pharmacy

You also may fill prescriptions at out-of-network pharmacies, but you'll pay more out of your own pocket when you do. You will need to file a claim for reimbursement for drugs purchased at an out-of-network **pharmacy**. See the section of this book entitled, Complaints, Claims and Appeals for more information.

Mail-Order Prescriptions – Aetna Rx Home Delivery

If you take medications on a regular basis for a chronic (ongoing) condition (such as high blood pressure, asthma, allergies or diabetes), you may order up to a 90-day supply through Aetna Rx Home Delivery, Aetna's mail-order drug service.

Aetna Rx Home Delivery is easy to use. To order by mail, send your original **prescription**, together with an order form and a check, money order or credit card number for the applicable **coinsurance** to Aetna. Order forms are available online at **www.covahealthaware.com**. You can also call the Health Concierge for forms.

Refills are simple, too. When you receive your original prescribed medication from the mail service program, you will also receive refill information. You can order refills by mail, by phone or online at **www.covahealthaware.com**.

Precertification

Your **physician** must request prior authorization by Aetna for certain **prescription drugs** before your **prescription** can be filled. This process is called **precertification**. **Precertification** helps encourage the appropriate and cost-effective use of **prescription drugs**.

The **precertification** program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's preferred drug list.

The drugs requiring **precertification** are subject to change. Call the Health Concierge at **1-855-414-1901** or visit Aetna's website for the current **precertification** List.

Step Therapy Program

The **prescription** drug coverage includes a step therapy requirement. Step therapy is a type of **precertification**. Certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. There may be times, however, when it is **medically necessary** for you to use a step-therapy medication as initial therapy without first trying a prerequisite therapy drug. In that situation, your doctor can request coverage of the step-therapy medication as a medical exception by contacting the **Pharmacy** Management **Precertification** Unit.

The step therapy program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, "cost information" includes any manufacturer rebate arrangements between Aetna and the manufacturers of certain drugs on Aetna's preferred drug list.

Covered Drugs

The Plan covers:

- Federal legend drugs (drugs that require a label stating: "Caution: Federal law prohibits dispensing without **prescription**") or any other drug that under the applicable state law may be dispensed only upon the written **prescription** of a **physician**.
- Compounded medication, of which at least one ingredient is a federal legend drug.
- Contraceptives, including oral and injectable contraceptives, patches and rings.

  The Plan covers over-the-counter FDA-approved contraceptives for women, including sponges, spermicides and female condoms, when purchased at an **in-network pharmacy**. You must have a **prescription** from your **physician**.
  Over-the-counter contraceptives for men are ***not*** covered.
- Diabetic needles and syringes.
- Immunization agents.
- Insulin.

- Over-the-counter diabetic supplies.
- Smoking cessation aids.
- Weight loss drugs. Your **physician** must get approval in advance from Aetna.

Preventive Drugs

The Plan covers100% of the cost of the following, with no **deductible**, when purchased at an **in-network pharmacy**:

- Aspirin to prevent heart disease for those age 45 or older.
- Oral **fluoride** for children age 6 months through age 5.
- Vitamin D for those age 65 and older.
- Folic acid supplements for women.

You must have a **prescription** from your **physician**.

Prescription Drug Refills for Travel

If you are planning to travel on vacation or leaving home for an extended period, you may need one or more early refills of your medication. Participating pharmacies may routinely provide one early refill (up to a 34-day or a 90-day supply, as appropriate) to accommodate travel. However, for extended travel, you should complete the **Prescription** Drug Refill Exception Request form available on the DHRM Web site at **www.dhrm.virginia.gov** or from your Benefits Administrator.

Mail or fax the completed form to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attention: Policy and Instruction
101 North 14th Street, 13th Floor
Richmond, VA 23219
Fax: (804) 371-0231

DHRM will approve all valid requests and forward them to Aetna. A member of Aetna's Member Services team will contact you to obtain specific medication information. Once you provide the medication information, a prior authorization will be entered for each medication requested and you will then have 14 days to complete your purchase.

Allow at least two weeks for complete processing of your request.

Please note:

- The maximum supply you may purchase at one time is 12 months;
- You will not be allowed to purchase more refills than prescribed. For example, if your one year **prescription** expires six months from the date of your request, you cannot purchase more than a six-month supply of medication;
- The Food and Drug Administration limits early refills on certain medications.

The Commonwealth reserves the right to bill a member for any months of medication remaining if employment terminates.

Prescription Drug Exclusions

The exclusions that apply to the medical plan (see What the Medical Plan Does Not Cover) apply to your **prescription** drug coverage. In addition, there are specific exclusions that apply to the **prescription** drug coverage. The Plan's **prescription** drug coverage does ***not*** include the following **prescription** drug expenses:

- Administration or injection of any drug. (Note that administration and injection of immunizations may be covered under the medical plan).
- Allergy sera and extracts.
- Any drug dispensed by a mail-order **pharmacy** other than Aetna Rx Home Delivery.
- Any drug entirely consumed when and where it is prescribed.
- Unless specifically outlined as covered in this handbook, any drug that does not, by federal or state law, require a **prescription**, such as an over-the-counter drug or equivalent over-the-counter product, even when a **prescription** is written for it.
- Any refill of a drug dispensed more than one year after the latest **prescription** for it, or as prohibited by law where the drug is dispensed.
- Biological sera, blood, blood plasma, blood products or substitutes, or any other blood products.
- Devices of any type (such as a spacer or nebulizer) used in connection with a **prescription** drug. Note that some devices may be covered as **durable medical equipment** or as part of another benefit.
- **Durable medical equipment**, monitors and other equipment.
- Erectile dysfunction:
  - Drugs to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy, regardless of diagnosis; and
- **Experimental and investigational** drugs or devices. This exclusion will not apply to drugs that:
  - Have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or
  - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
  - Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
- Food items, including infant formula, nutritional supplements, vitamins (including **prescription** vitamins), medical foods and other nutritional items, even when the item is the only source of nutrition. (Some special medical formulas may be covered as a medical supply—see Other Covered Services.
- Genetics: Any treatment, device, drug or supply to alter the body's genes, genetic make-up or the expression of the body's genes, except for the correction of congenital birth defects.
- **Infertility** treatment. The Plan does not cover drugs used primarily for the treatment of **infertility**, including drugs for, or related to, artificial insemination, in vitro fertilization or embryonic transfer procedures.
- Inpatient drugs: Any drug provided by a health care facility or while you are an inpatient there. Also, any drug provided on an outpatient basis by a health care facility if benefits are paid for it under any other part of this Plan or another plan sponsored by your employer.
- More than a 90-day supply of a **prescription** except for an approved travel supply.
- More than the number of refills specified by the prescribing doctor. Aetna may require a new **prescription** or proof of need if the **prescriber** has not specified the number of refills or if the frequency or number of refills seems excessive under accepted medical practice standards.
- Non-emergency **prescription drugs** bought outside of the United States if:
  - You travel outside of the U.S. to obtain the **prescription drugs** or supplies, even if they would be covered by the Plan if purchased in the U.S.;
  - The drugs or supplies are unavailable or illegal in the U.S.; or
  - The purchase of these drugs or supplies outside of the U.S. is illegal.

- Refill of a **prescription** if not more than 75% of the previous fill has been used if the drug was taken according to directions prescribed.
- Replacement of drugs or supplies that are lost, damaged, destroyed or stolen.
- Non-sedating antihistamines, even if they are used for other indications.

Employee Assistance Program

Overview

The Employee Assistance Program (EAP) is a confidential counseling service that is ready 24 hours a day, 7 days a week to help you with life issues. The EAP offers professional support and assistance when a family matter, financial concern, work-related problem or legal issue may seem overwhelming.

Find the help you need:	
You can access help and information in the way that's most comfortable for you	• face-to-face counseling: up to 4 visits per **plan year** for each eligible problem or issue • online resources: web access to information and self-directed resources
The EAP can help you with:	
Family	• planning for a family and pregnancy • conflicts between family members • caring for aging parents • adolescent challenges
Marriage	• communication • getting married • separation and divorce • domestic violence
Emotional health	• anxiety • depression • eating disorders • stress
Work	• balancing work and family • resolving conflicts • planning for retirement
Substance abuse	• impact on family relationships • treatment options
Death and dying	• terminal illness • grief
Financial • up to 30 minutes of telephone consultation with a staff financial counselor for each new issue (discount on additional consultations for the same issue)	• buying a home • mortgages and refinancing • budgeting • credit and debt • college funding • estate planning

The EAP can help you with:	
Taxes • up to 30 minutes of telephone consultation with a staff CPA or enrolled agent for each new issue (discount on additional consultations for the same issue) • discount on preparation of tax returns by a staff CPA	• tax questions • IRS matters • tax levy/garnishment resolution • tax return preparation
Identity theft • up to 60 minutes of telephone consultation with a staff Certified Fraud Resolution **Specialist** for each new issue	• identity theft • identity **restoration**
Legal • up to 30 minutes of telephone or face-to-face consultation with an attorney or mediator for each new issue (discount on additional consultations for the same issue) • discounts on "do it yourself" legal forms and document preparation services	• domestic/family conflict • landlord/tenant issues • criminal • motor vehicle violations

Eligibility

Employees and retiree group participants who are enrolled in the COVA HealthAware Plan and the members of their households may use the EAP's services.

How the EAP Works

When You Need Help

The EAP is available 24 hours a day, 7 days a week.

- *In an emergency*: If you are experiencing severe symptoms or you are in crisis and need immediate assistance, call your local 911 service or go to the nearest **hospital** emergency room.
- *For non-emergency situations*: Call the EAP at **1-888-238-6232.** You can talk with a clinician who will evaluate your situation, answer your questions and refer you to the appropriate resources, based on your need.

You and the members of your household are each eligible for up to four face-to-face EAP counseling sessions per condition or incident each year. There is no cost to you or your household members for these sessions.

You may require additional counseling. The COVA HealthAware medical plan's behavioral health benefits may cover continued services or treatment, possibly with the same counselor, allowing continuity in the transition from EAP to medical benefits for eligible plan participants.

Confidentiality

Maintaining your privacy is a high priority. All contact with the EAP is confidential to the extent permitted by law.

Online Resources

Web-based tools and resources are also available. Log in to **www.mylifevalues.com** (use "COVA" as the username and password). Your home page shows you a menu of EAP resources, so you can easily find the resources you need, including:

- Work-life support:
  - Locate convenience services such as cleaning, lawn and landscape, security and home maintenance.
  - Use the online concierge for travel and entertainment ideas.
  - Locate child care, elder care or care for someone who is disabled.
- Information about important health issues such as cancer, depression and aging.
- Discounts on products and services.
- Legal tools to help you create a will or financial power of attorney, plus sample forms and a library of legal articles.

Exclusions

The EAP does not provide:

- Inpatient treatment of any kind;
- Counseling with a psychiatrist;
- **Prescription drugs**;
- Counseling required by law or a court;
- Formal psychological evaluations; or
- More than four outpatient visits per **plan year** for each eligible problem, issue or incident.

To learn more about the EAP

Call the EAP at **1-888-238-6232** or go to **www.mylifevalues.com**, 24 hours a day, 7 days a week.

Your Basic Dental Coverage

The COVA HealthAware Plan covers diagnostic and **preventive care** only unless the optional Expanded Dental Plan is elected. You must be covered by the Plan on the date when you incur a covered dental expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends.

The Provider Network

The Plan gives you the freedom to choose any **dentist** or other dental care provider when you need diagnostic or **preventive care**. How much you pay out of your own pocket depends on whether the expense is covered by the Plan and whether you choose an **in-network provider** or an **out-of-network provider**.

Dentists and other providers that belong to Aetna's dental network are called **in-network provider**s. The providers in the network represent a wide range of services. When they join the network, providers agree to provide services or supplies for **negotiated charges**.

To find an **in-network provider** in your area:

- *Use DocFind at* **www.covahealthaware.com**. Follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you're willing to travel. You can search the online **directory** for a specific **dentist**, type of **dentist** or all the **dentist**s within a given zip code or travel distance. For more about DocFind®, refer to Resources,Tools and Programs.
- *Call the Health Concierge*. A Health Concierge can help you find an **in-network provider** in your area. You can also request a printed listing of network providers in your area without charge. The toll-free number for the Health Concierge is **1-855-414-1901**.

It's Your Choice

When you need diagnostic or preventive dental care, you have a choice. You can select a dental provider that belongs to the network (an **in-network provider**) or one that does not belong (an **out-of-network provider**). The Plan's benefit level is the same for **in-network care** and **out-of-network care**, but there are advantages to choosing a network provider:

- *If you use an **in-network provider***, you will probably save money because your share of the cost is based on the network provider's **negotiated charge** – you are not responsible for any amounts that are above the **negotiated charge**. You won't have to fill out claim forms, because your **in-network provider** will file claims for you.
- *If you use an **out-of-network provider,*** you may incur out-of-pocket cost for your care. The Plan pays benefits for **out-of-network care** based on 100% of the **recognized charge**. If your dental care provider charges more than the **recognized charge**, you are responsible for the excess amount. You may be required to pay all charges at the time of service and then file your own claims for **out-of-network care**.

What the Basic Dental Coverage Includes

Diagnostic and Preventive Services

Taking care of teeth now can prevent serious problems later. The Plan covers the following preventive services, without a **deductible**:

- Two routine oral exams per **plan year**. This includes prophylaxis (cleaning) of teeth. The Plan will cover cleaning and **scaling** by a licensed **dental hygienist** if supervised by a **dentist**.
- Two problem-focused exams per **plan year**.
- One topical application of sodium or stannous **fluoride** per **plan year** for covered children under age 19.
- One application of sealants to permanent molars every three years for covered children under age 19.
- Diagnostic X-rays and other X-rays, but no more than:
  - one full mouth series per three-year period, including Panorex;
  - two sets of **bitewing** X-rays per **plan year**;
  - periapical X-rays; and
  - one set of vertical **bitewing**s per three-year period.
- Space maintainers needed to preserve space resulting from premature loss of deciduous (baby) teeth, including all adjustments within six months after installation.
- One occlusal guard per three-year period to minimize the effects of bruxism (teeth grinding).
- Non-surgical treatment of TMJ disorder, including X-rays and **appliance** therapy.
- Emergency treatment for pain.

Participants who are pregnant or have coronary artery disease/cardiovascular disease, cerebrovascular disease or diabetes are also covered for the following additional dental services:

- One additional prophylaxis (cleaning) per year
- **Scaling** and root planing (4 or more teeth), per quadrant
- **Scaling** and root planing (limited to 1-3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance (one additional treatment per **plan year**)
- Localized delivery of antimicrobial agents (not covered for pregnancy)

What the Basic Dental Coverage Does Not Include

The COVA HealthAware basic dental plan does not cover restorative care or orthodontia. In addition, the basic dental plan does not cover:

- An illness, injury or condition that is related to your employment or self-employment.
- Charges for cancelled or missed appointments.
- Charges for drugs, devices, treatments or procedures that are **experimental and investigational**, as determined by Aetna.
- Charges made only because you have dental coverage.

- Charges that exceed the **recognized charge** for an out-of-network dental service, as determined by Aetna.
- Charges you are not legally obligated to pay.
- Claim form completion.
- Cosmetic services and supplies.
- Court-ordered services, including those required as a condition of parole or release.
- Dental services and supplies that are covered, in whole or in part, under any other part of this Plan or any other plan of group benefits provided by the Commonwealth of Virginia Health Benefits Program.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other purposes that are not **medically necessary** for dental health, and related expenses for reports, including report presentation and preparation.
- Instruction in diet, plaque and oral hygiene.
- Prescribed drugs, pre-medication and analgesia.
- Services and supplies Aetna determines are not necessary – even if they are prescribed, recommended or approved by a **physician** or **dentist**.
- Services and supplies given as part of treatment or care that is not covered by the Plan.
- Services and supplies given for your personal comfort or convenience, or the convenience of another person (including a provider).
- Services and supplies:
  - provided while you are in the care of a government authority;
  - to care for conditions related to past or present military service; or
  - provided, paid for or for which benefits are provided or required under any government law.
- Treatment that is not given by a **dentist** except for cleaning and **scaling** by a licensed **dental hygienist** if supervised by a **dentist**.

The Optional Expanded Dental Plan

The COVA HealthAware optional expanded dental plan covers restorative care (including **endodontics** and periodontics) and orthodontia treatment. You must be covered by the Plan on the date when you incur a covered dental expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends (except as described in Ordered but Undelivered Rule.

> ***Keep in Mind***
>
> The optional expanded dental plan covers expanded services. To be eligible for these services, you must elect the optional expanded dental plan and pay an additional monthly contribution for coverage.

The Provider Network

Like your basic dental coverage, the optional expanded dental plan gives you the freedom to choose any **dentist** or other dental care provider when you need covered services. How much you pay out of your own pocket depends on whether the expense is covered by the Plan and whether you choose an **in-network provider** or an **out-of-network provider**. Refer to It's Your Choice in the Basic Dental Plan chapter for information about the advantages of using an **in-network provider** and how to find an **in-network provider**.

When You Need Care That's Covered by the Expanded Dental Plan

An annual **deductible** applies to basic/primary restorative and major/complex restorative care. You must meet the applicable **deductible** before the Plan begins to pay benefits for covered dental expenses.

> ***Keep in Mind***
>
> The annual dental **deductible** applies to all covered care under the Optional Expanded Dental Plan. The annual **deductible** does not apply to **orthodontic treatment**.

Once you meet the **deductible**, the Plan pays a percentage of your covered dental expenses (the Plan's benefit) and you pay the rest (your **coinsurance**). The percentage paid by the Plan depends on the type of expense, as shown in Your Plan at a Glance.

The Plan's benefits for restorative care are subject to a **plan year** maximum benefit. There is a separate lifetime maximum benefit for **orthodontic treatment**. These maximum benefits are shown in Your Plan at a Glance.

> ***Keep in Mind***
>
> The **plan year** benefit maximum applies to all covered care.

Advance Claim Review

The purpose of the advance claim review is to determine – in advance – the benefits (if any) that the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

Keep in Mind

The advance claim review process is not a guarantee of benefit payment. It is an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

You should request an advance claim review whenever you or your **dentist** thinks a course of dental treatment is likely to be expensive (generally considered to be more than $250). Ask your **dentist** to write down a full description of the treatment you need, using the *Dental Benefits Request* form. The form is available online at **www.aetna.com.** Then, ***before*** treating you, your **dentist** should send the form to Aetna. Aetna may ask for supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your **dentist** with a statement that outlines how the Plan will cover the treatment. You and your **dentist** can then decide how to proceed.

The advance claim review is a voluntary service that gives you information that you and your **dentist** can consider when deciding on a course of treatment.

To determine the benefits payable, Aetna will consider alternate procedures, services or courses of treatment for the dental condition concerned in order to accomplish the appropriate result. (See Alternate Treatment Rule for more information about alternate dental procedures.)

What Is a Course of Dental Treatment?

A course of dental treatment is a planned program of dental services or supplies. The services or supplies are provided by one or more **dentist**s to treat a dental condition that was diagnosed by the attending **dentist** as the result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When this is the case, the Plan's coverage is limited to the least expensive service or supply that:

- Is considered by the dental profession to be appropriate for treatment; and
- Meets broadly accepted national standards of dental practice, taking into account your current oral condition, as determined by Aetna.

Here are some examples of alternate treatment and the benefit limits that apply:

- *Reconstruction:* The Plan covers only charges for the procedure needed to eliminate oral disease and replace missing teeth. The Plan does not cover an **appliance** or **restoration** needed to increase vertical dimension or restore occlusion.
- *Partial **dentures***: The Plan covers only charges for a cast chrome or acrylic **denture** if this satisfactorily restores an arch. This limit applies even if you and your **dentist** choose a more elaborate or precision **appliance**.
- *Complete **dentures***: The Plan covers only charges for a standard procedure. This limit applies even if you and your **dentist** choose personalized or specialized treatment.
- *Replacement of existing **denture**s*: This is covered only if the existing **denture** cannot be used or repaired. If it can be used or repaired, the Plan will cover only the charges for services needed to make the **denture** usable.

Ordered but Undelivered Rule

Your dental coverage may end while you are in the middle of treatment. The Plan does not cover any dental services that are given after your coverage terminates. There is an exception, however. The Plan will cover the following eligible services if they were ordered while you were covered by the Plan and installed within 30 days after your coverage ends:

- **Denture**s;
- Fixed **bridgework**;
- Removable bridges;
- Cast or process restorations;
- Root canals; and
- Inlays, onlays and **crown**s.

"Ordered" means:

- *For **dentures**:* the **impressions** from which the **denture** will be made were taken.
- *For a root canal:* the pulp chamber was opened.
- *For the other services listed above:* the teeth that will serve as retainers or supports, or the teeth that are being restored:
  - have been fully prepared to receive the item; and
  - impressions have been taken from which the item will be prepared.

What the Optional Expanded Dental Plan Covers

It's important to remember that the Plan covers only services and supplies that are **medically necessary** to prevent, diagnose or treat a dental condition. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The Plan pays benefits for covered services only. The benefit level for each type of covered service is shown in Your Plan at a Glance.

Primary Care

The optional expanded dental plan covers basic restorative care such as fillings and simple extractions. Once your annual **deductible** is met, the Plan pays 80% for the following covered expenses, subject to the **plan year** maximum benefit:

- Periodontic and endodontic treatment.
- Fillings.
- Full mouth debridement, once per lifetime.
- General anesthesia when provided in conjunction with a covered surgical procedure.
- **Endodontics**, including molar **root canal therapy**.
- Oral surgery, including routine post-operative care.

  Note: The removal of an impacted tooth (partial or completely bony) is considered a medical expense. Other oral surgery, such as simple extractions and osseous surgery, is considered a dental plan expense.
- Professional visits after regular office hours.
- Soft tissue grafts.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. Includes:
  - root planing and **scaling**, up to four separate quadrants per two-year period;

- gingivectomy; and
- periodontal maintenance following active therapy, up to two treatments per **plan year**.

Major (Complex) Restorative Care

The optional expanded dental plan covers major restorative care such as the replacement of natural teeth with **bridgework** or **dentures**. Once you've met your annual **deductible**, the Plan pays 50% for the following services, up to the **plan year** maximum benefit:

- Implants.
- Inlays, onlays and **crowns** when:
  - needed to treat decay or traumatic injury, and the tooth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial **denture** or fixed bridge.
- First installation of fixed **bridgework** (including inlays and **crowns** as abutments) to replace one or more natural teeth.
- First installation of removable **denture**s to replace one or more natural teeth. Coverage includes **relines**, **rebases** and adjustments within six months after the **denture**s are installed.
- Replacement of an existing removable **denture** or fixed **bridgework** with new fixed **bridgework**, if you meet the Prosthesis Replacement Rule (see below).
- Repair of **crowns**, **bridgework** or **denture**s.

Prosthesis Replacement Rule

Prosthetics (including **denture**s, **bridgework**, **crowns**, inlays and onlays) are subject to the Plan's replacement rule. In order for the Plan to cover certain replacements or additions, you must give Aetna proof that:

- You or your covered family member had a tooth (or teeth) extracted after the existing **denture** or **bridgework** was installed. As a result, you need to have teeth replaced or added to your **denture** or **bridgework**.
- The present **denture** or **bridgework** was installed at least five years before its replacement and cannot be made serviceable.
- The present **denture** is an immediate temporary one that replaces a tooth (or teeth). A permanent **denture** is needed and the temporary **denture** cannot be used as a permanent **denture**. Replacement must occur within 12 months from the date the immediate temporary one was first installed.

Orthodontic treatment

Orthodontia benefits cover the straightening of teeth with braces or other methods. Coverage for **orthodontic treatment** includes:

- Comprehensive **orthodontic treatment**;
- Interceptive **orthodontic treatment**;
- Limited **orthodontic treatment**; and
- Fixed and removable **appliance** therapy for harmful habits.

Benefits are limited to the lifetime maximum for **orthodontic treatment** shown in Your Plan at a Glance.

If **orthodontic treatment** begins before your effective date, this plan reduces its total allowance by the amount paid by a prior Commonwealth of Virginia plan. The combined payment for the prior coverage and coverage under your plan will not exceed $2,000.

If coverage ends during **orthodontic treatment**, this plan covers:

The banding portion of the service, only if the bands are installed before the date your coverage ends or follow-up visits if enrolled on the first day of the month when the visit takes place

The Plan does ***not*** cover:

- Changes in treatment because of an accident (see coverage under medical plan);
- Invisible braces (lingually placed direct bonded **appliance**s and arch wires);
- Maxillofacial surgery;
- Myofunctional therapy;
- Replacement of broken **appliance**s;
- Retreatment of orthodontic cases if lifetime maximum benefit has been exhausted;
- Surgical removal of impacted wisdom teeth when done for orthodontic reasons only;
- Treatment of cleft palate;
- Treatment of macroglossia; or
- Treatment of micrognathia.

> ***Keep in Mind***
> If your **orthodontic treatment** stops before it is complete, the Plan will cover only the services and supplies that were provided before treatment ended.

What the Optional Dental Plan Does Not Cover

In addition to the exclusions listed for the basic dental coverage (see What the Basic Dental Coverage Does Not Include), the following exclusions apply to the optional expanded dental plan:

Services and Supplies

The Plan does ***not*** cover:

- Acupuncture, acupuncture therapy or acupressure, except when performed by a **physician** as a form of anesthesia for surgery covered by the Plan.
- Intravenous sedation.
- Prescribed drugs, pre-medication and analgesia.
- Pontics, **crown**s, and cast or processed restorations made with high noble metals such as gold or titanium.
- Replacement of a lost, missing, stolen or damaged device or **appliance**, including the replacement of **appliance**s that have been damaged due to abuse, misuse or neglect.
- Services or **appliance**s to increase vertical dimension or restore occlusion.
- Services or **appliance**s used for splinting or to correct attrition, abrasion or erosion.
- Services to treat a jaw joint disorder or to alter bite or the alignment or operation of the jaw, except as described in What the Optional Dental Plan Covers. The Plan does not cover:
  - orthognathic surgery;
  - treatment of malocclusion; or
  - devices to alter bite or alignment.
- Services such as implant, abutment or **crown** that are the result of an accident (such as a blow to the mouth). See coverage for Oral Surgery for additional information.

- Work that was begun before the effective date of your coverage. For example:
  - If an **impression** was made for an **appliance** or a modification to an **appliance** before you were covered by the Plan, the **appliance** or modification is not covered.
  - If a tooth was prepared for a **crown** or bridge before you were covered by the Plan, the prosthetic is not covered.
  - If the pulp chamber was opened for **root canal therapy** before you were covered by the Plan, the therapy is not covered.

Cosmetic Services and Supplies

The Plan does ***not*** cover:

- Services or supplies that are cosmetic in nature, including personalization or characterization of **dentures**.
- Cosmetic, reconstructive or plastic surgery to improve, alter or enhance appearance, even if the surgery is performed for psychological or emotional reasons. The Plan covers such surgery only when it is needed to repair an injury, as long as the surgery is done in the calendar year of the accident or in the following calendar year.
- Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth.

Keep in Mind

Facings on molar **crowns** and pontics are always considered cosmetic.

The Optional Expanded Vision Plan

Your COVA HealthAware plan covers an annual routine vision exam as part of its basic medical benefit (see **Preventive care**). You must elect the optional Expanded Dental Plan and optional Expanded Vision Plan to be covered for the benefits described in this chapter.

> ***Keep in Mind***
> This is an optional benefit. You must pay an additional monthly contribution to be eligible for these benefits.

How Your Vision Coverage Works

The optional Expanded Vision Plan gives you the freedom to choose any vision care provider when you need vision services. How that care is covered and how much you pay out of your own pocket depend on whether the expense is covered by the vision care plan and whether you choose an **in-network provider** or an **out-of-network provider**.

- *If you use an **in-network provider***, you'll pay less out of your own pocket for your care. You won't have to fill out claim forms, because your **in-network provider** will file claims for you.
- *If you use an **out-of-network provider**,* you'll pay more out of your own pocket for your care and you may be required to file your own claims

Your Plan at a Glance shows how the level of coverage differs when you use in-network versus **out-of-network provider**s. In most cases, you save money when you use **in-network provider**s.

To find an **in-network provider** in your area:

- Use the online **directory** at **www.covahealthaware.com**; or
- Visit Aetna Vision online at **www.aetnavision.com** (you'll need to register by setting up your user ID and password); or
- Call Aetna Vision at **1-877-497-4817**.

What the Optional Expanded Vision Plan Covers

Lenses and Frames

The Plan covers eyeglass or contact lenses and frames. You share the cost of care, as shown in Your Plan at a Glance. The Plan does not pay for both eyeglass and contact lenses in the same **plan year**. Frames are covered once per **plan year**.

Lenses

The Plan covers the following eyeglass lenses, up to one pair per **plan year**:

- Single vision
- Bifocal vision
- Trifocal vision
- Lenticular vision
- Progressive vision

The Plan offers discounts on the following lens options:

- Anti-reflective coating
- Plastic scratch coating
- Polarized/other add-ons
- Standard polycarbonate lenses
- Tint (solid and gradient)
- UV treatment

Refer to Your Plan at a Glance for more information about allowances, **copayments**, **coinsurance** and discounts.

Frames

The Plan covers any available frame, including frames for **prescription** sunglasses once per **plan year**, up to the allowance. Discounts may be available for additional frames.

Contact Lenses

The Plan covers contact lens fittings and conventional and disposable contact lenses:

- Contact lenses: you may choose to receive contact lenses instead of eyeglass lenses.
- Standard contact fitting (in-network only): applications of clear, soft, spherical, daily-wear contact lenses for single-vision prescriptions.

  Note: Fittings for extended/overnight wear lenses are considered premium, not standard, contact lens fittings. See below.
- Premium contact lens fitting (in-network only): more complex applications, including (but not limited to) toric (astigmatism .62D or higher in the contact lens), multifocal/monovision, post-surgical and gas permeable lenses. Includes extended/overnight wear for any **prescription**.

The Plan also covers **medically necessary** contact lenses, such as lenses needed as a result of:

- Keratoconus where your sight is not correctable to 20/30 in either or both eyes using standard spectacle lenses and your vision provider attests to visual improvement with contact lenses.
- High ametropia exceeding – 10D or +10D in spherical equivalent.
- Anisometropia of 3D in spherical equivalent or more.
- Vision that can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Discounts

After you use your initial frame or lens benefit allowance, you can take advantage of discounts on additional **prescription** eyeglasses, replacement contact lenses, eyewear accessories, and Lasik and PRK procedures at any time. Discounted products and services include:

- Additional complete pair of eyeglasses (as many as you like);
- Replacement contact lenses;
- Additional eyewear and accessories, Including eyeglass frames and eyeglass lenses purchased separately, lens cleaning supplies and contact lens solutions; and
- Lasik vision correction or PRK, when the service is obtained from a provider in the U.S. Laser Network. Call **1-800-422-6600** for more information.

Refer to Your Plan at a Glance for more information about the discounts that apply.

> ***Keep in Mind***
>
> Discounts are only available from **in-network provider**s.

What the Optional Expanded Vision Plan Does Not Cover

The Plan does not cover every vision care service or supply, even if prescribed, recommended or approved by your provider. The Plan covers only those services and supplies that are described in What the Optional Expanded Vision Plan Covers.

In addition to the medical plan exclusions listed in What the Medical Plan Does Not Cover, the following exclusions apply to the vision plan:

- Any charges in excess of the benefit, dollar or supply limits shown in Your Plan at a Glance.
- Any exams given during your stay in a **hospital** or other facility for medical care.
- Duplicate or spare eyeglasses or lenses or frames for them.

  Note: although the Plan does not cover duplicate, spare or replacement glasses, lenses and frames, you can still take advantage of discounts that are available for additional glasses, lenses and frames. Refer to Your Plan at a Glance for more information about these discounts.
- Drugs or medicines.

  Note: **Medically necessary** drugs and medicines are covered by the medical plan.
- Eye exams.

  Note: Eye exams are covered by the medical plan. Refer to Routine Eye Exams for more information.
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

  Note: While the surgery is not covered, discounts may be available for certain services. Refer to Your Plan at a Glance for more information.
- **Prescription** sunglasses or light sensitive lenses in excess of the amount that would be covered for non-tinted lenses.
- Replacement of lost, stolen or broken **prescription** lenses or frames.
- Special supplies such as subnormal vision aids.
- Special vision procedures, such as orthoptics, vision therapy or vision training.
- Vision services that are covered in whole or in part under any workers' compensation law or any other law of like purpose.
- Vision services or supplies that do not meet professionally accepted standards.

Your Health and Wellness Program

ActiveHealth Management

As a part of your COVA HealthAware Plan, you have access to health and wellness tools through ActiveHealth Management to help you protect and improve your health. You can register to use these resources online at **www.MyActiveHealth.com/COVA** or you can contact ActiveHealth Management by calling **1-866-938-0349**.

> ***Participants Living Abroad***
>
> If you live outside of the United States, you can access ActiveHealth resources online at **www.MyActiveHealth.com/COVA** or by calling **1-866-938-0349**. You will not receive letters or phone calls from ActiveHealth Management, but you can call in to speak with a nurse or coach.

Participation is voluntary. If you do not wish to participate in any health and wellness programs, you may opt out by calling **1-866-938-0349**. If you opt out of the program, you will not be eligible for any incentives, including premium rewards.

Health and wellness programs include:

Health Assessment

Taking a health assessment (either online or by calling **1-866-938-0349**) can be the first step toward helping you take control of your health. Once you complete the health assessment, ActiveHealth gives you personalized health and wellness resources to help you reach your personal health goals. You can choose the resources that are right for you. MyActiveHealth.com/COVA is secure, so your information is protected and confidential.

Completing the health assessment may also help you to earn a premium reward, which can reduce the cost of your medical coverage. Your open enrollment materials and other communications will include information regarding any premium reward opportunities.

> ***Remember:***
>
> Premium rewards are different than "Do-Rights." Completing "Do-Rights" provides opportunities to increase your HRA contribution—see Your COVA HealthAware HRA for more information.

Healthy Lifestyles

Whether you want to work on one area of your health or many, the Healthy Lifestyles Coaching program can help you get on – and stay on – your personal path to wellness. Your personal health coach can help you:

- Lose weight
- Quit smoking
- Eat better
- Get in shape
- Manage stress

Your health coach will work with you to choose the behaviors you want to work on, set realistic goals and plans to ensure success, work through challenges that might hold you back and celebrate your successes. You'll talk privately, over the phone, when it's convenient for you.

To get started, visit your ActiveHealth portal at **www.MyActiveHealth.com/COVA** or call **1-866-938-0349**.

Healthy Insights

The Healthy Insights program is designed to make it easier for you to manage a chronic (long-term) health condition and live your life well. You can work with a personal nurse coach to:

- Understand your condition and what you can do to manage it;
- Identify and manage your risks for other conditions; and
- Make changes to reach your personal health goals.

You can talk with your nurse coach – by phone or online – whenever you have a question or could use some advice.

Participation is voluntary. If you have a long-term condition, such as those listed below, call ActiveHealth at **1-866-938-0349** to sign up for the program. ActiveHealth may also reach out and invite you to participate.

- Arthritis
- Asthma
- Blood clots
- Breast cancer
- Chronic back pain
- Chronic hepatitis B or C
- Chronic kidney disease
- Chronic neck pain
- Colon cancer
- COPD
- Crohn's disease
- Cystic fibrosis
- Diabetes (see Diabetes Management Program)
- Disease of leg arteries/PAD
- GERD/gastric reflux disease
- Heart attack and angina
- Heart failure
- High blood pressure
- High cholesterol
- HIV
- Kidney failure
- Leukemia
- Lung cancer
- Lupus
- Lymphoma
- Migraines
- Osteoporosis
- Overweight/obesity
- Parkinson's disease
- Prostate cancer
- Seizures
- Sickle cell anemia
- Stomach ulcers
- Stroke
- Ulcerative colitis

Diabetes Management Incentive Program

As a part of the Healthy Insights Program, the Diabetes Management Program provides covered generic and preferred brand diabetic supplies and drugs at no cost to you if you fulfill all of the following requirements:

- Participate in a minimum of quarterly coaching calls;
- Follow-up with your **physician** each **plan year**;
- Have at least one HbA1c test each **plan year**;
- Take your diabetes medications as prescribed by your **physician**; and
- Complete an initial compliance period of 90 days.

Contact ActiveHealth at 1-866-938-0349 if you have questions.

Healthy Beginnings

If you're expecting a baby, the Healthy Beginnings maternity support program can help you stay well throughout your pregnancy and after your baby is born. You'll have regular phone calls with your personal ActiveHealth nurse who can help you:

- Follow a healthy diet and lifestyle;
- Understand your prenatal tests and the results;

- Find a **specialist** if you need one;
- Recognize the signs of early labor; and
- Take care of yourself and your newborn after delivery.

Call **1-866-938-0349** to sign up for the program. Your nurse will set up appointments so you can talk throughout your pregnancy, and you can call your nurse any time if you have a question. If you enroll within the first 16 weeks of your pregnancy and fulfill all program requirements, you will earn a $300 contribution to your HRA.

Bariatric Pre-Surgery Program

If you are seeking bariatric surgery, you are required to participate in a 12-month pre-surgery education program. The goal of this program is to help bariatric surgery candidates break through personal barriers to achieve safe and effective long-term weight loss.

Your bariatric surgeon must contact Aetna's Provider Precertification to determine if you qualify for the program. To qualify, you must weigh at least 100 pounds over or twice the ideal body weight for your frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables. You must have a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes OR you have a body mass index of 40 kilograms per meter squared, without such comorbidity. If you meet these criteria, Aetna will notify ActiveHealth Management so that you can start the program. Once pre-certified, you must contact ActiveHealth within 30 days of approval in order to begin. After completing the program, you, your surgeon and Aetna will determine if you are eligible to move forward to surgery.

Once you're enrolled in the pre-surgery program, an ActiveHealth Management nurse coach will provide 12 months of one-on-one, goal-oriented support. Your weight coach will help you understand the emotional and behavioral issues that are often linked to weight problems and work with you toward nutrition and exercise goals. The program includes:

- Weight management and nutrition counseling; and
- Personalized coaching and disease management.

If you comply with all program requirements and move forward to surgery, you can earn an additional contribution to your HRA to help you pay your out-of-pocket costs ($300 if you have inpatient surgery, $125 if you have outpatient surgery). After the surgery, you can continue with personalized coaching for up to 24 months. This will help you transition to the changes in your life required for a long-term successful outcome of your surgery.

Personal Health Website

The MyActiveHealth.com/COVA web site has health tips, tools and trackers to get you on the road to good health. It also gives you quick access to your personal health information. You can review your Health Record that stores and retrieves information about doctor's visits, prescriptions, tests and more. It also provides Action Items that identify things you can do for your health and offers videos, recipes and other helpful tools to address your personal health goals. MyActiveHealth.com/COVA is secure and in compliance with all privacy requirements.

Personal Health Alerts – Care Considerations

ActiveHealth Management uses technology to review health records to help you and your enrolled family members get safe, high-quality healthcare. If the review process finds something you and your doctor should know about, it lets you both know by sending a personalized communication called a Care Consideration. If you receive a Care Consideration, you should talk to your doctor.

Eligibility, Enrollment and Changes

This section describes who is eligible for coverage, how to enroll for coverage, when coverage goes into effect and what happens when you want to make a change.

Who Is Eligible for Coverage

You are eligible for coverage if you are:

- A part- or full-time, salaried, classified employee, or similarly situated employee at an independent state agency; or
- A regular, full-time or part-time salaried faculty member.

A full-time salaried employee is one who is scheduled to work at least 32 hours per week, or carries a faculty teaching load considered to be full time at his institution. A part-time employee is eligible if he or she is scheduled to work at least 20 hours per week. Your eligible dependents also may be covered. With the exception of adult incapacitated dependents, the term" dependent" in this section means an eligible family member. Retirees, LTD participants, and survivors, collectively referred to as "retiree group participants," may also be eligible for coverage as described later in this section.

You may choose your type of membership as follows:

- Employee/retiree group participant single – to cover yourself only;
- Employee/retiree group participant plus one – to cover yourself and one eligible dependent; or
- Family – to cover yourself and two or more eligible dependents.

Participants who fail to remove ineligible persons within 60 days of their loss of eligibility event may be removed from the program for a period of up to three years. In addition, the participant will be responsible for claims paid in error and will be unable to reduce health benefits membership except during open enrollment or with a consistent qualifying mid-year event.

Eligible Dependents

The following dependents are eligible for coverage under your Health Plan:

- The employee's/retiree's legal spouse. The marriage must be recognized as legal in the Commonwealth of Virginia.
- The employee's/retiree's children. Under the health benefits program, the following eligible children may be covered to the end of the calendar year in which they turn age 26, the Plan's limiting age (the age requirement is waived for adult incapacitated children):
  - Natural children.
  - Adopted children, and children placed for adoption.
  - Stepchildren. A stepchild is the natural or legally adopted child of your legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.
  - Other children. An unmarried child for whom a court has ordered the employee/retiree (and/or the employee's/retiree's legal spouse) to assume sole permanent custody. The principal place of residence is with the employee/retiree, the child is a member of the employee's/retiree's household, the child receives more than one-half of his or her support from the employee/retiree, and the custody was awarded prior to the child's 18th birthday. Additionally, if the employee/retiree or spouse shares custody with their minor child who is the parent of the "other child," then the other child may be covered. The other child, the parent of the other child and the spouse, if the spouse is the one who has shared custody, must be living in the same household as the employee/retiree.

When the minor child, who is the parent of the other child, reaches age 18, the employee/retiree must obtain sole permanent custody of the other child and provide this documentation to the Benefits Administrator.

– Incapacitated dependents. Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by your Health Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the Plan's limiting age. You must make written application, along with proof of incapacitation, prior to the child reaching the Plan's limiting age. Such extension of coverage must be approved by your Health Plan and is subject to periodic review. Should your Health Plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from your Health Plan to the enrollee. The child must live with you as a member of your household, not be married, and be dependent upon you for financial support. In the cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with you. Furthermore, the support test is met if either you or the other parent or combination of the employee and other parent provide more than one-half of the child's financial support.

  Adult incapacitated children of new employees who have been continuously incapacitated may also be covered, provided that:

  - The enrollment form is submitted within 30 days of hire;
  - The child has been covered continuously as an incapacitated dependent on a parent's group employer coverage since the incapacitation first occurred, or as a Medicaid/Medicare recipient;
  - The incapacitation commenced prior to the child attaining the limiting age of your Health Plan; and
  - The enrollment form is accompanied by a letter from a **physician** explaining the nature of the incapacitation and date of onset, and certifying that the dependent is not capable of financial self-support. This extension of coverage must be approved by the Health Plan in which the employee or spouse is enrolled.

Adding Adult Incapacitated Dependents as a Qualifying Mid-Year Event

Adult incapacitated dependents that are enrolled as an incapacitated dependent on a parent's group employer coverage, or in Medicare or Medicaid, may be enrolled in the State Health Benefits Program with a consistent qualifying mid-year event (as defined by the Office of Health Benefits) if:

- The dependent remained continuously incapacitated;
- Eligibility rules are met;
- Required documentation is provided; and
- The **Claim administrator** for the plan in which the employee is enrolled approves the adult dependent's condition as incapacitating.

Eligibility rules require that the incapacitated dependent lives at home, is not married, and receives more than one-half of his or her financial support from the employee.

The following documentation is required by the **Claim administrator** to approve the dependent's coverage:

- Evidence that the dependent has been covered continuously as an incapacitated dependent on a parent's group employer coverage, or covered under Medicaid or Medicare, since the incapacitation first occurred;

- Proof that the incapacitation commenced prior to the end of the year during which dependent attained the limiting and that the dependent was covered continuously until that time; and
- An enrollment form adding the dependent within 60 days of the qualifying mid-year event, accompanied by a letter from a **physician** explaining the nature of the incapacitation and date of onset and certifying that the dependent is not capable of financial self-support. Additionally the Plan reserves the right to request additional medical information and to request an independent medical examination.

If an incapacitated dependent leaves the State Health Benefit Program and later wants to return, the review will take into consideration whether or not the same disability was present prior to them reaching the Plan's limiting age and continued throughout the period that the child was not covered by the State Health Benefits Program. If the dependent was capable of financial self-support as an adult, and then backtracked into disability, the disability is considered to have begun after the Plan's Limiting Age and the person cannot be added to the State Health Benefits Program.

Adult incapacitated dependents are not eligible to join the plan during the annual open enrollment period.

When an adult incapacitated dependent, or any covered family member, loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

You cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. However, there is an exception for certain adopted children. If you are a U.S. citizen or U.S. national who has legally adopted a child who is not a U.S. citizen, U.S. resident alien or U.S. national, you may cover the child, if the child lives with you as a member of your household all year. This exception also applies if the child is lawfully placed with you for legal adoption.

Documentation Requirements

You must provide proof of eligibility any time you add a dependent to health care. The chart below shows the documentation required. In addition, documentation is required for each qualifying mid-year event.

Dependent	Eligibility Requirement	Documentation Required
Spouse	The marriage must be recognized as legal in the Commonwealth of Virginia. Note: Ex-spouses will not be eligible, even with a court order.	• Photocopy of marriage certificate; and • Photocopy of the top portion of the first page of the employee's most recent Federal Tax Return that shows the dependent listed as "Spouse." NOTE: All financial information and Social Security Numbers can be redacted.
Natural or Adopted Son/Daughter	A son or daughter may be covered to the end of the year in which he or she turns age 26.	Photocopy of birth certificate or legal adoptive agreement showing employee's name Note: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits.

Dependent	Eligibility Requirement	Documentation Required
Stepson or Stepdaughter	A stepson or stepdaughter may be covered to the end of the year in which he or she turns age 26.	• Photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; and • Photocopy of marriage certificate showing the employee and dependent parent's name; and • Photocopy of the most recent Federal Tax Return that shows the dependent's parent listed as "Spouse." Note: All financial information and Social Security Numbers can be redacted.
Other Female or Male Child	Unmarried children for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody may be covered until the end of the year in which he or she turns age 26 if: • The principal place of residence is with the employee; • They are a member of the employee's household; • They receive more than one-half of their support from the employee and • The custody was awarded prior to the child's 18th birthday.	• Photocopy of birth certificate: and • Photocopy of the Final Court Order granting permanent custody with presiding judge's signature.
Other Female or Male Child – Exception	If the employee (or employee's spouse) shares custody with his or her minor child who is the parent of an "other female or male child," then that "other child" may also be covered if the other child, the minor child (who is the parent) and the employee's spouse (if applicable): • All live in the same household as the employee; • Both children are unmarried; and • Both children received more than one-half of their support from the employee. The minor child must meet all of the eligibility requirements for a dependent child. Once the minor child turns 18, the employee or spouse, if applicable, must receive sole custody of the other child.	• Photocopy of the other child's birth certificate showing the name of the minor child as the parent of the other child; • Photocopy of the birth certificate (or adoptive agreement) for the minor child showing the name of the employee; and • Photocopy of the Final Court Order with presiding judge's signature.

Dependent	Eligibility Requirement	Documentation Required
Incapacitated Adult Dependents	The employee's adult children who are incapacitated due to a physical or mental health condition may be covered beyond the end of the year in which he or she reaches the limiting age if: • They are unmarried; • They reside full-time with the employee (or the other natural/adoptive parent); • The employee provides more than half of the dependent's support; • They are deemed incapacitated prior to the end of the year in which they reach age 26; and • They have maintained continuous coverage under an employer-sponsored plan of the employee (or the other natural/adoptive parent). Coverage through Medicare or Medicaid will be deemed coverage through the employee.	• Photocopy of birth certificate or legal adoptive agreement showing employee's name. • In the case of a new employee, copy of the HIPAA Certificate showing prior employer-sponsored coverage. • Other medical certification and eligibility documentation as needed.

When a covered family member loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Coverage for Retirees and Long Term Disability (LTD) Participants

Retirees and LTD participants who enroll within 31 days of starting retirement or losing eligibility for coverage as an active employee may be eligible for coverage under the Health Plan until they become eligible for Medicare (either due to age or disability). Eligibility of family members for the retiree group does not differ from that of active employees.

Who Is Not Eligible For Coverage

There are certain categories of persons who may not be covered under the program. These include siblings, grandchildren, nieces and nephews, except where the criteria for "other children" are satisfied. Parents, grandparents, aunts, uncles and any other individuals not specifically listed as eligible in this chapter are not eligible for coverage, regardless of dependency status.

Enrollment and Changes

There are only certain times when you may enroll yourself and eligible family members in a health benefits plan, or change your type of membership or plan. You must remove anyone who is no longer eligible for the Plan within 60 days of losing eligibility. You risk suspension from the health benefits program for up to three years if you cover individuals who do not qualify.

When Newly Eligible

You have up to 30 calendar days to enroll from your date of hire or becoming eligible. The 30-day countdown period begins on the first day of employment and ends 30 days later. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month following the date of employment or eligibility. If that date is the first of the month, your coverage begins that day.

There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before your first day of employment. In addition, once you have submitted an election within 30 days of employment, that election is binding and may not change after it takes effect.

Full-Time to Part-Time

When your employment status changes from full-time to part-time, your health care election automatically terminates at the end of the month that you cease to be a full-time employee because the Commonwealth of Virginia does not contribute to the cost of coverage for part-time employees. You continue to be eligible for health care coverage as a part-time employee; however, you must re-enroll in coverage within 60 days of the last day you are in full-time employment status. As a part-time classified employee, you are responsible for paying the total cost for health care. There will be no employer contribution unless required per provisions of the Affordable Care Act.

Retirement

Retirees eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect coverage under the Health Plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in the Health Plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date. New retirees may not increase membership based on retirement, but they may increase membership with the occurrence of a separate qualifying mid-year event that would allow the increase.

Non-Medicare eligible retiree group participants may make membership and plan changes upon the occurrence of a qualifying mid-year event and at open enrollment. Retiree group participants may reduce membership level at any time, and the effective date will be the first day of the month after the notification is received by their Benefits Administrator. However, retirees who cancel their own coverage may not return to the program. Termination of the retiree group participant will result in termination of any covered family members.

Long Term Disability

Long Term Disability (LTD) participants eligible for coverage in the State Retiree Health Benefits Program but not eligible for Medicare may elect coverage under the Health Plan if they enroll in the retiree group within 31 days of the date that their coverage or eligibility for coverage as an active employee ends. They may also waive coverage within 31 days of their loss of active employee coverage or eligibility for coverage, and preserve their right to return with a qualifying mid-year event or at open enrollment, as long as they are not eligible for Medicare.

Like non-Medicare eligible retirees, non-Medicare eligible LTD participants may make membership and plan changes upon the occurrence of a qualifying mid-year event or at open enrollment, and they may reduce their membership level prospectively at any time. However, LTD participants who cancel their own coverage outside of open enrollment and without a qualifying mid-year event, or who are terminated for non-payment of their coverage while enrolled in the retiree group, will not be reinstated at any level for the duration of the LTD period.

During Open Enrollment

Health benefits open enrollment occurs in the spring for employees and non-Medicare-eligible retiree group participants. The spring open enrollment is your opportunity to make changes in your health benefits plan and/or type of membership. The benefits and contribution costs associated with your open enrollment elections will be effective July 1 through June 30 of the following **plan year**.

Qualifying Mid-Year Events (Changes Outside Open Enrollment)

You may make membership and plan changes during the **plan year** that are based on qualifying mid-year events. You must submit your change within 60 calendar days of the event. The countdown begins on the day of the event. Normally the change will be effective the first of the month after the date the submission of an election change is received. There are two exceptions to the prospective election date. These include HIPAA special enrollments and terminations required by the plan, both of which are addressed in more detail later in this section.

The following events permit a change outside of open enrollment. You may change a benefit election when a valid qualifying mid-year event occurs, but only if your change is made **on account of, and corresponds with**, a qualifying mid-year event that affects your own, your spouse's or another family member's eligibility for coverage. Also, once you have submitted a valid election, that election is binding after it takes effect. If you have questions about these events, contact your Benefits Administrator.

- Birth, adoption, or placement for adoption*
- Child covered under your Health Plan lost eligibility
- Death of child
- Death of spouse
- Divorce
- Employment change – full-time to part-time
- Employment change – part-time to full-time
- Employment change – unpaid leave of absence
- Gained eligibility under Medicare or Medicaid
- HIPAA special enrollment
- Judgment, decree, or order to add child
- Judgment, decree, or order to remove child
- Lost eligibility under governmental plan
- Lost eligibility under Medicare or Medicaid
- Marriage
- Move affecting eligibility for health care plan
- Other employer's open enrollment or plan change
- Spouse or child gained eligibility under his/her employer's plan
- Spouse or child lost eligibility under his/her employer's plan

* Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The employee/retiree group participant must be party to the support agreement and the agreement must extend beyond the obligation to provide medical coverage.

HIPAA Special Enrollment

If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, under a *HIPAA Special Enrollment* you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage).

However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

If you are eligible for health coverage, but not covered in a state health plan, there are two additional circumstances under the Health Insurance Portability and Accountability Act (HIPAA) that will permit you to enroll. You may enroll when:

- You or your dependent loses coverage in Medicaid or the State Children's Health Insurance Program (SCHIP) and you request coverage under the Plan within 60 days of the time your coverage ends; or
- You or your dependent becomes eligible for a Medicaid or SCHIP premium assistance subsidy and you request coverage under the Plan within 60 days after your eligibility is determined.

Special Enrollment Provisions for Birth, Adoption or Placement for Adoption

An exception to prospective changes is Health Plan coverage for newborns, adopted children and those children placed for adoption. In these events, Health Plan coverage will be retroactive to the date of birth, adoption or placement for adoption.

However, in some cases, employees or retiree group participants may make the Health Plan coverage election on a prospective basis. If the employee or retiree group participant can provide documentation of coverage for the month of birth, adoption or placement for adoption, then the child's coverage in the State's plan can be effective the first of the month following receipt of the enrollment action.

In all cases the employee has 60 days from the date of the event to decide which option to choose (retroactive or prospective enrollment).

Terminations Required by the Plan

You can only provide coverage for family members who meet the Health Plan's eligibility definition. Terminations required by the Plan due to loss of eligibility would include events such as divorce, death of a dependent and a child's loss of eligibility (such as reaching the Plan's limiting age). In cases where there is a loss of eligibility, the effective date of the change is based on the date of the event.

You still have 60 calendar days to submit the enrollment action to remove the ineligible family member. However, the change is effective the end of the month in which the family member lost eligibility. Once the family member has been removed from coverage, your membership may be reduced. If the membership is reduced, the agency should refund contributions paid for the higher membership following the loss of eligibility. If you do not make an enrollment action within the 60-day time frame, then the current membership level will be maintained, the family member will be removed from coverage at the end of the month during which the loss of eligibility event took place, but there will be no reduction in contribution level until the next **plan year**. (Some exceptions may apply to retiree group participants.)

When Coverage Ends

Coverage ends on the last day of the month during which eligibility is lost. Unless otherwise stated below or agreed to in writing by the Commonwealth of Virginia, Department of Human Resource Management, the covered person's coverage ends on the last day of the month for which full payment is made. When a covered person ceases to be eligible or the required contributions are not paid, the covered person's coverage will end.

Examples of a covered person's loss of eligibility include:

- When you leave your job with the employer, or change from full-time to hourly employment.

  Note: Employees changing from full-time to part-time employment remain eligible; however, coverage for an employee making this change is cancelled and the employee must re-enroll if continued coverage is desired. Part-time employees are responsible for paying the total health benefits contribution.

- When a covered child reaches the end of the year in which the child turns 26.
- In the case of an incapacitated dependent, when the child is no longer incapacitated.
- In the case of a spouse, when the employee or retiree group participant and spouse divorce.

  Note: Coverage will end for the enrolled spouse and stepchildren of a member on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly reported, elected and maintained. A former spouse or stepchildren cannot be covered after the end of the month during which the final divorce is granted, even if there is a court order requiring the employee/retiree group participant to provide coverage, except under the provisions of Extended Coverage.

Benefits will not be paid for charges you incur after your coverage ends.

When You Become Eligible for Medicare

You may remain enrolled under this Health Plan as long as you continue working and meet the other eligibility requirements. See your Benefits Administrator for more information. Contact the nearest Social Security Office or go to **www.ssa.gov** when you or a family member becomes eligible for Medicare (due to age or disability) if you need more information or would like to enroll. Medicare benefits are secondary to benefits payable under this Plan for individuals who have coverage as a result of their own or their spouse's active employment status with the Commonwealth of Virginia as a large group health plan.

The state plan is required to offer to their active employees age 65 or over or otherwise eligible for Medicare, and their Medicare-eligible family members the same coverage as they offer to employees and their family members who are not eligible for Medicare (except when Medicare eligibility is due to End Stage Renal Disease and the coordination period is exhausted, Medicare becomes primary to the state plan, even if the coverage is due to active employment). Medicare beneficiaries may terminate active employee coverage within 60 days of Medicare entitlement and retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such active employees or covered family members secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare Supplement policies for beneficiaries who have coverage based on current active employment status.

Participating retirees, LTD participants, survivors and their dependents who become eligible for Medicare, whether due to age or disability, and wish to continue participation in the State Retiree Health Benefits Program, must immediately enroll in one of the program's Medicare-coordinating plans. To ensure access to supplemental benefits, they must enroll in Medicare Parts A and B immediately upon eligibility. Failure to enroll in Parts A and B may result in coverage deficits since the program's Medicare-coordinating plans will not pay any part of a claim that would have been covered by Medicare had the participant been properly enrolled in Medicare. If it is determined that a retiree group participant is eligible for Medicare but has continued coverage in this or any non-Medicare coordinating plan, primary claim payments made in error may be retracted.

For more information about coordination of benefits with Medicare, call **1-800-MEDICARE** (1-800-633-4227) or go to **www.medicare.gov**.

When an Employee or Retiree Group Participant Dies

Covered family members of active employees retain coverage until the last day of the month after the month during which the employee's death occurred. The employee's family members may elect Extended Coverage. Also, if a state employee dies while in service, survivor benefits may be available to:

- Beneficiaries who will immediately receive a survivor benefit from the Virginia Retirement System; or
- Family members who are covered under the State Health Benefits Program at the time of the employee's death and wish to continue coverage (per the Code of Virginia).

The deadline to enroll as a survivor is 60 days from the date of the employee's death. Contact the Benefits Administrator of the agency in which the state employee worked to enroll in survivor coverage.

Upon the death of a retiree or LTD participant, covered survivors are covered until the last day of the month in which the death occurs, and eligible survivors may obtain additional retiree group coverage as follows:

- Surviving family members for whom Virginia Retirement System survivor benefits have been provided may enroll in survivor coverage within 60 days of the retiree's/LTD participant's death, regardless of whether they had coverage prior to the retiree's/LTD participant's death (provided the retiree/LTD participant was still eligible for coverage at the time of death). Annuitant surviving spouses may continue coverage as long as the conditions outlined in the policies and procedures of the Department of Human Resource Management are met. Eligible surviving children may be covered through the end of the year in which they turn age 26 if they continue to meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.
- Surviving family members who are enrolled in the program at the time of the retiree's/LTD participant's death may continue coverage in the retiree group by enrolling as survivors within 60 days of the retiree's/LTD participant's death. Non-annuitant surviving spouses may continue coverage until the end of the month in which they remarry, obtain alternate health plan coverage, or cease to meet any other applicable eligibility condition outlined in the policies and procedures of the Department of Human Resource Management. Eligible surviving children may be covered until the year in which they turn age 26 if they continue to meet all other conditions for eligibility stated in the policies and procedures of the Department of Human Resource Management.

Participating survivors who become eligible for Medicare must enroll in a Medicare-coordinating plan.

Extended Coverage

You and/or your covered family members lose coverage due to certain qualifying events, as described in this chapter, you can elect Extended Coverage per the provisions of the Public Health Service Act.

> ***Please Note***
> As used in this chapter, the terms "you" and "your" refer to an employee of the Commonwealth of Virginia (the State).

General Notice of Extended Coverage Rights

This notice generally explains Extended Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act that covers employees of state and local governments. Extended Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under your Health Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under your Health Plan and under the law, you should contact your designated Benefits Administrator.

What Is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your covered children could become qualified beneficiaries if coverage under your Health Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under your Health Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage contributions will be included in the *Election Notice* provided at the time of the qualifying event.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under your Health Plan because of either one of the following qualifying events:

- Your hours of employment are reduced. This would include periods of leave without pay (even if the employer contribution toward the cost of coverage continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or change in the terms and conditions of the employer contribution toward the cost of coverage.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you lose your coverage under your Health Plan because of any one of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer contribution toward the cost of coverage continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or change in the terms and conditions of of coverage);

- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from your spouse.

Your covered children will become qualified beneficiaries if they lose coverage under your Health Plan because of any one of the following qualifying events:

- The parent/employee/retiree dies;
- The parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer contribution toward the cost of coverage continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or change in the terms and conditions of coverage);
- The parent's/employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced, resulting in loss of dependent eligibility; or
- The child stops being eligible for coverage as a child under Your Health Plan.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When Is Extended Coverage Available?

Your Benefits Administrator will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- Termination of employment;
- Reduction in hours of employment resulting in loss of coverage and/or change in the terms and conditions of coverage, including leaves without pay; or
- Death of the employee.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse or a covered child's loss of eligibility for coverage), you or your representative must notify your Benefits Administrator within 60 days of the qualifying event (or within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- The type of qualifying event (for example, divorce or loss of a covered child's eligibility, including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or covered child's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree);
- The written signature of the notifying party; and
- If the address of record is incorrect, an address for mailing the *Election Notice*.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, on the date it is received by your Benefits Administrator.

How Is Extended Coverage Provided?

Once the designated Commonwealth of Virginia Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee/retiree, your divorce or a covered child's loss of eligibility, Extended Coverage lasts for up to a total of 36 months.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

  For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months.

There are two ways by which this 18-month period can be extended.

1) Disability extension of 18-month period of continuation coverage

You and anyone in your family covered under the Extended Coverage provisions of Your Health Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage, and the disability lasts at least until the end of the 18-month initial period of continuation coverage. The Office of Health Benefits Extended Coverage Administrator must receive notification of the disability determination within 60 days of either:

a) the date of the disability determination;

b) the date of the qualifying event;

c) the date on which coverage would be lost due to the qualifying event; or

d) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice),

AND within the first 18 months of Extended Coverage.

Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary;
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative);
- If the address of record is incorrect, a correct mailing address.

2) Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and covered children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format

and time frame specified below) to the Office of Health Benefits Extended Coverage Administrator. The extension may be available to the spouse and any covered children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse or the covered child ceases to be eligible under Your Health Plan, but only if the event would have caused the spouse or child to lose coverage under Your Health Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- The type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or covered child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree);
- The written signature of the notifying party; and
- If the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, on the date it is received by the Extended Coverage Administrator.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Benefits Administrator for more information.

If You Have Questions

Questions concerning your Health Plan or your Extended Coverage rights should be addressed to the contact listed below under Plan Contact Information.

Plan Contact Information

For information about Extended Coverage, initial notification of qualifying events and initial enrollment, contact your agency Benefits Administrator.

To make changes to Extended Coverage after initial enrollment, contact:

Office of Health Benefits
Extended Coverage Administrator
101 N. 14th Street, 13th Floor
Richmond, VA 23219

Keep your Benefits Administrator Informed of Address Changes

In order to protect your family's rights, you should keep your Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Benefits Administrator or the Office of Health Benefits Extended Coverage Administrator.

Coordination With Other Plans

Coordination of Benefits (COB)

COB helps to prevent duplicate payments from benefit plans for the same services. COB is an important provision because it helps to control the cost of your health care coverage. COB rules apply when you have additional health care coverage through other group health plans, including:

- Group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured.
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans or employee benefit organization plans.
- Coverage under any tax-supported or government program to the extent permitted by law.

As a new participant, you will need to respond to a request for coordination of benefits information when you get your first Explanation of Benefits. You should also notify Aetna if your coverage changes during your employment. You are responsible for ensuring that Aetna has accurate, up-to-date information on file. This means notifying Aetna if you add other coverage, change existing coverage or your other coverage cancels.

Primary Coverage and Secondary Coverage

When a covered person in this Plan is also enrolled in other group health plan coverage, one coverage will be primary (pay its benefits first) and the others will be secondary, tertiary, etc. Which coverage will be primary and which secondary, etc., is made using the order of benefit determination rules. Aetna will use the rules listed below, in the order shown, to determine which plan is primary. The first rule that applies in the chart below will determine which plan pays first:

If . . .	Then . . .
1. One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
2. One plan covers you as a family member and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
3. You are a Medicare-entitled covered family member of an active employee Note: Medicare-eligible retiree group participants and/or their Medicare-eligible family members are not eligible for this Plan.	These Medicare Secondary Payer rules apply: • The plan that covers you as a family member of a working parent or spouse determines its benefits and pays first. • Medicare pays second. • If you have additional coverage to supplement Medicare, that plan pays third. Note: Different rules apply when eligibility is due to End Stage Renal Disease.
4. A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.

If . . .	Then . . .
5. A child's parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child's health expenses to either parent, or states that both parents are responsible for the child's health coverage	The "birthday rule" described above applies.
6. A child's parents are separated or divorced, and a court decree assigns responsibility for the child's health expenses to one parent	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.
7. A child's parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibility for the child's health expenses to either parent	Benefits are determined and paid in this order: a) The plan of the custodial parent pays, then b) The plan of the spouse of the custodial parent pays, then c) The plan of the non-custodial parent pays, then d) The plan of the spouse of the non-custodial parent pays.
8. You have coverage: • as an active employee (that is, not as a retired or laid-off employee) and also have coverage as a retired or laid-off employee; or • as the dependent of an active employee and also have coverage as the dependent of a retired or laid-off employee	The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
9. You are covered under a federal or state right of continuation law (such as COBRA)	The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
10. The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When your Health Plan is the primary coverage, it pays first. When your Health Plan is the secondary coverage, it pays second as follows:

- Aetna calculates the amount your Health Plan would have paid if it had been the primary coverage; then
- Coordinates this amount with the primary plan's payment. Your Health Plan's payment in combination with the other plan's payment will never exceed the amount your Health Plan would have paid if it had been your primary coverage.

Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, your Health Plan will assign a reasonable cash value for the services and that will be considered the primary plan's payment. Your Health Plan will then coordinate with the primary plan based on that value.

In no event will your Health Plan pay more in benefits as secondary coverage than it would have paid as primary coverage.

No COB for Vision Care

The Optional Vision Plan does not include a COB provision and does not coordinate with other plans.

Overpayment of Benefits

If your Health Plan overpays benefits because of COB, your Plan has the right to recover the excess from:

- Any person to, or for whom, such payments were made;
- Any employer;
- Any insurance company; or
- Any other organization.

Your Cooperation Is Required

You must cooperate with your Health Plan to secure this right.

Complaints, Claims and Appeals

You have access to both a complaint process and an appeal process. Should you have a problem or question about this Plan, contact the Aetna Health Concierge at **1-855-414-1901** for assistance. Most problems and questions can be handled in this manner. However, you may file a complaint or an appeal as explained in this chapter.

Complaints

Complaints typically involve issues such as dissatisfaction about your plan's services, quality of care, or choice of, and accessibility to, **in-network provider**s. The Plan has procedures for you to follow if you are dissatisfied with the service you receive or with an **in-network provider**. To make a complaint about an operational issue or the quality of care you've received, you must submit your complaint in writing to Aetna within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant. Aetna will review the information and give you a written decision within 30 calendar days of the receipt of the complaint, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will tell you what you need to do to seek an additional review.

Send your written complaint to:

Aetna
P O. Box 981106
El Paso, TX 79998-1106

Claims

The Plan has procedures for submitting claims, making decisions on claims and filing an appeal when you don't agree with a claim decision. You and Aetna must meet certain deadlines that are assigned to each step of the process, depending on the type of claim.

Types of Claims

To understand the claim and appeal process, you need to understand how claims are defined:

- *Urgent care claim:* A claim for medical care or treatment where delay could seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- *Pre-service claim:* A claim for a benefit that should be approved in advance to ensure coverage (**precertification**).
- *Concurrent care claim extension:* A request to extend a course of treatment that was previously approved.
- *Concurrent care claim reduction or termination:* A decision to reduce or terminate a course of treatment that was previously approved.
- *Post-service claim:* A claim for a benefit that is not a pre-service or a concurrent claim.

Keeping Records of Expenses

It is important to keep records of medical expenses for yourself and your covered dependents. You will need these records when you file a claim for benefits. Be sure you have this information for your medical records:

- Name and address of **physician**s;
- Dates on which each expense was incurred; and
- Copies of all bills and receipts.

Filing Claims

You will receive an Explanation of Benefits (EOB) describing your claim payment (or denial of coverage) whenever a claim is filed on your behalf.

If you use an **out-of-network provider**, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from the Aetna Health Concierge by calling the number on your ID card, or by going online at **www.aetna.com**. The form has instructions on how, when and where to file a claim.

File your claims promptly – ***the filing deadline is 12 months after the end of the plan calendar year in which you received the service***. If, through no fault of your own, you are unable to meet that deadline, your claim will be accepted if you file it as soon as possible.

You may file claims and appeals yourself or through an "authorized representative," who is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

Physical Exams

Aetna has the right to require an exam of any person for whom **precertification** or benefits have been requested. The exam will be done at any reasonable time while **precertification** or a claim for benefits is pending or under review. The exam may be performed by a doctor or **dentist** Aetna has chosen, and it will be done at no cost to you.

Time Frames for Claim Processing

Aetna will make a decision on your claim.

- *If Aetna approves the claim,* Aetna will send you an Explanation of Benefits (EOB) that shows you how Aetna determined the benefit payment. Aetna will pay benefits to the service provider unless you give Aetna different instructions when you file the claim.

  Keep in Mind

  You can receive your EOBs via U.S. mail or electronically on your secure member web site. If you'd like to receive electronic EOBs, log on to Aetna Navigator at **www.aetna.com**, and follow the instructions to *Turn Off Paper* under *Claims*.

- *If Aetna denies your claim,* Aetna must give you a written notice of the denial. The chart below shows when Aetna must notify you that your claim has been denied.

Type of Claim	Aetna Must Notify You
Urgent care claim	As soon as possible, but not later than 72 hours The determination may be provided in writing, electronically or orally. If the determination has been provided orally, a written or electronic notification will be sent no later than 3 calendar days after the oral notification.
Pre-service claim	15 calendar days
Concurrent care claim extension	• Urgent care claim – as soon as possible, but not later than 24 hours, provided the request was received at least 24 hours before the end of the approved treatment • Other claims – 15 calendar days
Concurrent care claim reduction or termination	With enough advance notice to allow you to appeal
Post-service claim	30 calendar days

Extensions of Time Frames

The time periods described in the chart may be extended, as follows:

- *For urgent care claims:* If Aetna does not have enough information to decide the claim, you will be notified as soon as possible (but no more than 24 hours after Aetna receives the claim) that additional information is needed. You will then have at least 48 hours to provide the information. A decision on your claim will be made within 48 hours after you provide the additional information.
- *For non-urgent pre-service and post-service claims:* The time frames may be extended for up to 15 additional days for reasons beyond the Plan's control. In this case, Aetna will notify you of the extension before the original notification time period has ended.

  If an extension of time is needed because Aetna needs more information to process your post-service claim:

  – Aetna will notify you and give you an additional period of at least 45 days after receiving the notice to provide the information.
  – Aetna will then inform you of the claim decision within 15 days after the additional period has ended (or within 15 days after Aetna receives the information, if earlier).

  If you do not provide the information, your claim will be denied.

Notice of Claim Denial

A claim denial is also called an adverse benefit determination. An adverse benefit determination is a decision Aetna makes that results in denial, reduction or termination of:

- A benefit; or
- The amount paid for a service or supply.

It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  – It is not included in the list of covered benefits;
  – It is specifically excluded;

- It is not **medically necessary**; or
- A Plan limit or maximum has been reached.

Aetna will send you written notice of an adverse benefit determination. The notice will give you:

- The reason or reasons that your claim was denied.
- A reference to the specific plan provisions on which the denial was based.
  - If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, you'll either receive:
    - a copy of the actual rule, guideline, protocol or other criterion; or
    - a statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge.
  - If the denial is based on a plan provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll either receive:
    - an explanation of the scientific or clinical judgment for the determination; or
    - a statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and the reason why the material or information is necessary.
- .
- An explanation of the expedited claim review process for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax, then follow up with a written or electronic notice within three days after the notification.

Appealing an Adverse Claim Decision

Two Steps in the Appeal Process

The Plan provides for two levels of internal appeal to Aetna, plus an option to seek external review by the Department of Health Resources Management (DHRM):

- You must request your internal appeal within 15 months of the date of service or 180 calendar days after you receive the notice of a claim denial, whichever is later.
- After you have exhausted the internal appeal process, you may file a voluntary appeal for external review by the DHRM if your claim meets certain requirements. You must submit a request for external review within four months of the date you receive a final denial notice from Aetna.

How to Appeal a Claim Denial: Internal Appeals

Your internal appeal may be submitted in writing to the address on your Aetna ID card or by making a phone call to the Aetna Health Concierge at 1-855-414-1901. Your appeal should include:

- Your name, address and telephone number;
- Your member ID number (found on your Aetna ID card);
- Your employer's name;
- A copy of Aetna's notice of the adverse benefit determination (make sure this shows the date of the service in question and the provider's name);
- The specific medical condition;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Based on the type of claim, Aetna must respond to your appeal within the time frames shown in the following chart:

Type of Claim	Level One Appeal
Urgent care claim	Will respond within 72 hours, with follow-up written confirmation within 24 hours
Pre-service claim	Will respond within 30 calendar days
Concurrent care claim extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-service claim	Will respond within 60 calendar days

The review will be performed by Plan personnel who were not involved in making the adverse benefit determination.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna. In the cast of an urgent care claim or a pre-service claim, a **physician** familiar with the case may represent you in the appeal.

If the Level One and Level Two appeals uphold the original adverse benefit determination for a *medical* claim, you may have the right to pursue an external review of your claim by the DHRM. See External (DHRM) Appeals for details.

External (DHRM) Appeals

After internal appeals are exhausted, you may request an external appeal to DHRM.

For external appeals, you may only appeal adverse benefit determinations by the **Claim administrator** (Aetna) that are based on:

- Your Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit;
- The failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental and investigational**; or
- A rescission of coverage (whether or not the rescission has any effect on any particular benefit).

Just as with internal appeals, in some circumstances, you have the right to an expedited external appeal. See Expedited External Appeals below for more information.

You or your authorized representative must submit the following information to the Director of the Virginia Department of Human Resource Management (DHRM):

- Your full name;
- Your identification number;
- Your address;
- Your telephone number;
- The date(s) of the medical service;
- Your specific medical condition(s) or symptom(s);
- Your provider's name;
- The service or supply for which approval of benefits is being sought; and
- Any reasons why the appeal should be processed on an expedited basis.

You may also submit any additional information you wish to have considered in this review. However, you do not have to re-send any information that you sent to the **Claim administrator** to consider during your internal appeal.

Claims appeals will be referred to an independent review organization (IRO) that will render a written decision. The decision is binding on your Health Plan, but if the decision is not in your favor, you have the

right to further appeal to the circuit court under the Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Administrative Process Act.

Standard External Appeals

Standard (non-expedited) external appeals must be submitted in writing to DHRM by traditional mail, e-mail or facsimile within four (4) months after the final adverse decision by your **Claim administrator**.

You may download an appeals form at **www.dhrm.virginia.gov**.

- To appeal by traditional mail, send your request to the following address:

  Director, Virginia Department of Human Resource Management
  101 N. 14th Street – 12th Floor
  Richmond, VA 23219

  Please mark the envelope: **Confidential – Appeal Enclosed**.

- To use e-mail, send your request to appeals@dhrm.virginia.gov
- To use facsimile, fax your request to **1-804-786-0356**.

If your appeal request is incomplete or ineligible for external review, DHRM will inform you within six (6) business days of the reason(s) for ineligibility and what information or materials are needed to make your appeal request complete.

If your appeal request is complete and eligible for external review, DHRM will notify you within six (6) business days of the name and contact information of the independent review organization deciding your appeal. You will then have five (5) business days to provide any additional information to the independent review organization. The independent review organization has the discretion to accept additional information provided after this deadline.

Within forty-five (45) days after the independent review organization receives your appeal request, the independent review organization will send you or your authorized representative written notification of its decision.

Expedited External Appeals

Expedited external appeals may be submitted to DHRM by telephone, facsimile or e-mail at the time that you receive:

- An adverse decision from the **Claim administrator**, if the adverse decision involves a medical condition for which the time frame for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- A final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves a medical condition for which the time frame for completing a standard external appeal (see Standard External Appeals above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision 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; or
- A final adverse decision of an internal appeal from the **Claim administrator**, if the adverse decision involves prescriptions to alleviate cancer pain.

If you intend for your appeal to be expedited, clearly write “expedited” on the appeal request (and envelope, fax cover sheet or e-mail subject line as appropriate).

- To appeal by traditional mail, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219
Please mark the envelope: Confidential – Expedited Appeal Enclosed.

- To use e-mail, send your request to appeals@dhrm.virginia.gov.
- To use facsimile, fax your request to **1-804-786-0356**.
- To appeal by telephone, call **1-804-786-0353**.

If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify you of the reason(s) for ineligibility.

If your expedited appeal is complete and eligible for external review, the independent review organization will notify you or your authorized representative of its decision within 72 hours of the independent review organization's receipt of your appeal request. If this notification is given verbally, the independent review organization will send you or your authorized representative a written decision within 48 additional hours.

However, if the expedited appeal involves a determination that a requested medical service is **experimental and investigational**, then the following rules apply:

- The appeal must be accompanied by a written certification from your treating **physician** that the health care service or treatment would be significantly less effective if not promptly started.
- If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify you of the reason(s) for ineligibility.
- If your appeal is complete and eligible for external review, the independent review organization will notify you of its decision within seven (7) business days. If this notification is given verbally, a written notice will follow within 48 hours.

Other Appeals to DHRM

If an appeal involves an adverse eligibility determination (these are adverse determinations made by DHRM), then it should be submitted in writing to the Director of the Virginia Department of Human Resource Management (DHRM). Appeals to the Director must be filed within four (4) months of Your Health Plan's action or appropriate notification of that action, whichever is later.

To file such an appeal, you or your authorized representative must submit the following information to the Director of DHRM:

- Your full name;
- Your identification number;
- Your address;
- Your telephone number;
- A statement of the adverse decision you are appealing;
- What specific remedy you are seeking in filing this appeal; and
- Any reasons why the appeal should be processed on an expedited basis.

You may download an appeals form at **www.dhrm.virginia.gov**.

To appeal by traditional mail, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219
Please mark the envelope: Confidential – Appeal Enclosed.

To use e-mail, send your request to appeals@dhrm.virginia.gov

To use facsimile, fax your request to **1-804-786-0356**.

You have the right to submit written comments, documents, records and other information supporting your claim. The appeal will take into account all information that you submit, regardless of whether it was submitted or considered in the initial determination.

DHRM does not accept appeals for matters in which the sole issue is disagreement with policies, rules, regulations, contract or law. If you are unsure whether an eligibility determination can be appealed, call the Office of Health Benefits at **1-804-225-3642** or **1-888-642-4414**.

You are responsible for providing DHRM with all information necessary to review the denial of your claim. You will be allowed to submit any additional information you wish to have considered in this review, and you will have the opportunity to explain, in person or by telephone, why you think the determination should be overturned.

These appeals will be decided by the Director of DHRM, who will render a written decision. If the decision is not in your favor, you have the right to further appeal through the Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Administrative Process Act.

Claim Fiduciary

Claim decisions are made by the Claim Fiduciary in accordance with the provisions of the Plan. The Claim Fiduciary has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether **hospital** or medical treatment is, or is not, **medically necessary**. In exercising its fiduciary responsibility, the Claim Fiduciary has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Interpret the provisions of the Plan when a question arises.

The Claim Fiduciary has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration. The Claim Fiduciary may not act arbitrarily or capriciously, which would be an abuse of its discretionary authority.

The Plan provides for two standard levels of appeal for adverse benefit determinations.

DHRM serves as the Claim Fiduciary that will provide full and fair review.

Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to you, or on your behalf, and the **Claim administrator** finds at a later date the payments were incorrect, the **Claim administrator** will pay any underpayment.

If the **Claim administrator** makes a benefit payment over the amount that you are entitled to under this Plan, the **Claim administrator** has the right to:

- Require that the overpayment be returned on request; or
- Reduce any future benefit payment by the amount of the overpayment.

This right does not affect any other right of overpayment recovery the **Claim administrator** may have.

Fraud and Abuse

If you suspect fraud or abuse involving a claim, please notify Aetna by calling an Aetna Health Concierge at **1-855-414-1901** to report the matter for investigation.

Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the **Claim administrator**, the State or the Plan in any matter relating to (1) your Health Plan, (2) the **Claim administrator**'s performance or the State's performance under your Health Plan; or (3) any statements made by an employee, officer, or director of the **Claim administrator**, the State, or the Plan concerning your Health Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event you or your representative sues the **Claim administrator**, the State, the Plan, or any director, officer, or employee of the **Claim administrator**, the State, or the Plan acting in a capacity as a director, officer or employee, your damages will be limited to the amount of your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed.

In no event will this contract be interpreted so that punitive or indirect damages, legal fees or damages for emotional distress or mental anguish are available.

Administrative Information

The Department's Right to Change, End and Interpret Benefits

Your Health Plan is sponsored by the Commonwealth of Virginia (the State) and administered by the Department of Human Resource Management (the Department). The Department is authorized to, and reserves the right to, change or terminate your Health Plan on behalf of the State at any time. These retained rights extend, without limit, to all aspects of your Health Plan, including benefits, eligibility for benefits, provider networks, the cost of coverage and contributions required of employees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of your Health Plan and such discretionary determination will be binding on all parties.

You and Your Provider

You have the right to select your own provider of care. Services provided by an institutional provider are subject to the rules and regulations of the Health Plan option you select. These include rules about admission, discharge and availability of services. Neither the **Claim administrator**, the State nor the Department:

- Guarantees admission or the availability of any specific type of room or kind of service.
- Will be responsible for acts or omissions of any facility.
- Will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a facility.
- Will be liable for breach of contract because of anything done, or not done, by a facility.

Similarly, the **Claim administrator** is obligated only to pay, in part, for the services of your professional provider to the extent the services are covered. Neither the **Claim administrator**, the State nor the Department:

- Guarantees the availability of a provider's services.
- Will be responsible for acts or omissions of any provider.
- Will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a provider.
- Will be liable for breach of contract because of anything done, or not done, by a provider.

The same limitations apply to services rendered or not rendered by a provider's employee.

You must tell the provider that you are eligible for services. When you receive services, show your Health Plan identification card. Show only your current card.

Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer your coverage. The information often comes from medical care facilities and medical professionals who submit claims for you. Collected information is disclosed to others only in accordance with the guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA) and in the Virginia Insurance Information and Privacy Protection Act.

When you apply for coverage under the Health Plan, you agree that the **Claim administrator** may request any medical information or other records from any source when related to claims submitted to the **Claim administrator** for services you receive.

By accepting coverage under the Health Plan, you authorize any individual, association or firm that has diagnosed or treated your condition to furnish the **Claim administrator** with necessary information, records or copies of records. This authorization extends to any person or organization that has any information or records related to the service received or to the diagnosis and treatment of your condition.

If the **Claim administrator** asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information that applies to you. But, subject to the above, a participant may review copies of medical records that pertain to enrolled children under age 18 as allowed by law.

Assignment of Benefits

Plan benefits are personal; that is, they are available only to you and your covered family members. You may not assign (give to another person) your right to receive services or payment, except as provided in law. Prior payments to anyone will not constitute a waiver of or in any way restrict the **Claim administrator**'s right to direct future payments to you or any other individual or facility, even if there has been an assignment of payment in the past.

You and the **Claim administrator** agree that other individuals, organizations and health care practitioners will not be beneficiaries of the payments provided under this Plan. This explanation of services and payments available to you is not intended for anyone else's benefit. As such, no one else (except for your personal representative in case of your death or mental incapacity) may assert any rights described in this handbook or provided under your Health Plan.

Benefits Administrator and Other Plan Information

Your Benefits Administrator is the person appointed by your employer to assist you with your health care benefits. Your Benefits Administrator may also provide you information about your benefits. If there is a conflict between what your Benefits Administrator tells you and your Health Plan, your benefits will, to the extent permitted by law, be determined on the basis of the language in this handbook. The Benefits Administrator is never the agent of the **Claim administrator**.

The Plan Administrator may send general communications to your Benefits Administrator to be distributed to you. You may be provided with another booklet, brochure, employee communication or other material that describes the benefits available under your Health Plan. In the event of conflict between this type of information and your Health Plan, your benefits will be determined on the basis of the language in this handbook.

Claim administrator's Continuing Rights

On occasion, the **Claim administrator** or the State may not insist on your strict performance of all terms of your Health Plan. Failure to apply terms or conditions does not mean the **Claim administrator** or the State waives or gives up any future rights it may have. The **Claim administrator** or the State may later require strict performance of these terms or conditions.

Services after Amendment of Your Health Plan

A change in your Health Plan will change covered services available to you on the effective date of the change. This means that your coverage will change even though you are receiving covered services for an ongoing illness, injury or pregnancy-related condition, or if you may need more services or supplies in the future.

Misrepresentation

A member's coverage can be canceled by the Plan Administrator or the State if it finds that any information needed to accept the member or process a claim was deliberately misrepresented by, or with the knowledge of, the member. The Plan Administrator or the State may also cancel coverage for any other family members enrolled with the member. If there is a fraud or an intentional misrepresentation of material fact, the Plan Administrator or the State may cancel coverage retroactive to the date of the fraud or misrepresentation.

Non-Payment of Monthly Charges

If you are required to pay monthly contributions to maintain coverage, and such contributions are late, the **Claim administrator** has the right to suspend payment of your claims. The **Claim administrator** will not be responsible for claims for any period for which full monthly charges have not been paid. If your monthly contributions remain unpaid 31 days from the date due, the State may instruct the **Claim administrator** to cancel your coverage.

HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA) Creditable Coverage

In the event that you leave this Health Plan and go to a health plan that includes a pre-existing condition waiting period, you may be eligible for creditable coverage. The following list is considered creditable coverage and your new health plan may reduce the pre-existing condition waiting period by the amount of time, if any, you were covered by the following similar plans:

- Medicare, Medicaid, TRICARE, a medical care program of the Indian Health Service Program or a tribal organization, a Health Benefit Plan under the Peace Corps Act, a State health benefits risk pool, or any other similar publicly sponsored program;
- A group health benefit plan;
- A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et. Seq.);
- A public health plan (as defined in federal regulations);
- Your current employer's eligibility waiting period;
- Health insurance coverage consisting of benefits for medical care issued by an insurer, a health maintenance organization, a health service plan or a fraternal benefit society; or
- Individual health insurance coverage.

When you leave this Plan, your Benefits Administrator will provide you with proof of prior coverage (certificate of coverage) for your new health plan, if needed. A sample of this certificate, as well as a form to request a certificate, follows.

Certificate of Group Health Plan Coverage

Date of this certificate: _____

Name of participant: _____

Name of health care plan: _____

Participant's identification number: _____

Membership level (Single, Employee + One, Family): _____

Name of individuals to whom this certificate applies: _____

Was the period of creditable coverage more than 18 months? (disregard periods of coverage before a 63-day break.) (Yes/No): _____

If less than 18 months, date coverage began: _____

Date coverage ended: _____

Date waiting period began: Not applicable

Person preparing this certificate and to whom questions should be addressed:

Name: _____

Address: _____

_____

Telephone number: _____

Email address: _____

Agency: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

This certificate is evidence of your coverage under the Plan. You may need evidence of coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan or to get certain types of individual health coverage even if you have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). You may obtain additional certificates for you or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should you need them during the 24 months following your termination from the Plan.

Pre-Existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the plan or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk with your new Plan Administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to Get Special Enrollment in Another Plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption and placement for adoption.)

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition Against Discrimination Based on a Health Factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to Individual Health Coverage

Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for Extended Coverage (COBRA) or you have exhausted your Extended Coverage (COBRA) benefits; and
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off or fired or quit your job.

Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For More Information

If you have questions, you may contact the person who prepared this certificate (contact information included). You may also contact the:

- U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at **1-866-444-3272** (for free HIPAA publications ask for publications concerning changes in health care laws); or
- CMS publications hotline at **1-800-633-4227** (ask for "Protecting Your Health Insurance Coverage").

These publications and other useful information are also available on the Internet at:

- **www.dol.gov/ebsa**, the U.S. Department of Labor's interactive web pages – Health Elaws; or
- **www.cms.hhs.gov/HealthinsReformforConsume.**

Request for Certificate of Group Health Plan Coverage

Use this form to request a Certificate of Group Health Plan Coverage from your Benefits Administrator. You may obtain additional certificates for you or your covered family members upon request while you are covered by the Plan and during the 24 months following your termination from the Plan.

Date of request: _____

Name of participant: _____

Address: _____

_____

Telephone number: _____

Email address: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above):

_____

_____

_____

_____

Disclosure of Protected Health Information (PHI) to the Employer

1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.
   a) Plan - means the “State Health Benefits Programs.”
   b) Employer - means the “Commonwealth of Virginia.”
   c) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
   d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.
   e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
   f) Summary Health Information - means information that summarizes the claims history, expenses or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state. Except five digit zip codes ; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; and (5) facial photographs or biometric identifiers (e.g., finger prints).
   g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.
2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan.
3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.
4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:
   a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
   b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;

c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);

e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;

f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;

g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;

h) to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and

i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

5) The Plan will disclose PHI only to the following employees or classes of employees:

Director, Department of Human Resource Management
Director of Finance, Department of Human Resource Management
Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered “failure to comply with established written policy” (a Group II offense) and must be addressed under the Commonwealth of Virginia’s Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

Important Notice: Prescription Drug Coverage and Medicare

If you are an active employee of the Commonwealth of Virginia who is covered under this Plan, and you and/or any of your covered dependents are also eligible for Medicare, please read the following information carefully and keep it where you can find it. This notice has information about your current **prescription** drug coverage with the Commonwealth of Virginia Health Benefits Program and about your options under Medicare's **prescription** drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help in making decisions about your **prescription** drug coverage is at the end of this notice.

Medicare **prescription** drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare **Prescription** Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers **prescription** drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Commonwealth of Virginia Health Benefits Program has determined that the **prescription** drug coverage offered by the COVA HealthAware Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare **prescription** drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare **prescription** drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year during the Annual Coordinated Election Period designated by Medicare. This may mean that you have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later and do not have creditable coverage for 63 or more days. You may pay that higher premium (a penalty) as long as you have Medicare **prescription** drug coverage. However, if you lose creditable **prescription** drug coverage through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Medicare drug plan (a Part D plan). In addition, if you lose or decide to leave employer or union-sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage under the Commonwealth of Virginia Health Benefits Program, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare **prescription** drug coverage in your area to determine the plan that is best for you.

If you decide to join a Medicare drug plan, your Commonwealth of Virginia coverage based on active employment (yours or your spouse's) will generally not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your Commonwealth of Virginia coverage as an active employee or covered family member of an active employee (based on the policies and procedures of the Department of Human Resource Management and applicable law), be aware that you and/or your covered family member(s) will not be able to return to this coverage except with the occurrence of a consistent qualifying mid-year event or at open enrollment. The Commonwealth of Virginia Health Benefits Program does not offer a medical plan to active employees that excludes **prescription** drug coverage. Consequently, you must either maintain full coverage under an available Commonwealth of Virginia plan (including **prescription** drug coverage) or terminate coverage completely. You do not have the option of terminating only the **prescription** drug benefit under your Commonwealth of Virginia plan. Your employing agency's Benefits Administrator can provide additional information about making plan/membership changes or terminating coverage.

At the time an Enrollee and/or covered family member becomes eligible for Medicare, he/she may keep his/her state plan coverage based on current/active employment or may terminate coverage under the

Commonwealth of Virginia Health Benefits Program based on that event if termination is requested within 31 days of eligibility for Medicare. However, once coverage has been terminated, neither the employee nor the family member may re-enroll in the state program except upon the occurrence of a consistent qualifying midyear event (for example, loss of eligibility for Medicare) or at open enrollment. An eligible family member may not enroll unless the employee is enrolled. If an active employee or the covered family member of an active employee has both the state program's coverage and Medicare, except in limited circumstances, the state plan coverage will be primary and Medicare will be secondary.

You should also know that if you drop or lose your coverage with the Commonwealth of Virginia Health Benefits Program for active employees and their eligible family members and don't join a Medicare drug plan before 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without **prescription** drug coverage that's at least as good as Medicare's **prescription** drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare **prescription** drug coverage. In addition, you may have to wait until the following Annual Coordinated Election Period to join a plan, and coverage will generally not begin until the following January.

For more information about this notice or to obtain a personalized notice, contact your agency Benefits Administrator. For more information about your current **prescription** drug coverage, consult the appropriate section of this Member Handbook or the Aetna Health Concierge.

Keep in Mind

You will get this notice prior to the Medicare Part D annual enrollment period each year that you participate in the Commonwealth of Virginia Health Benefits Program for active employees and are eligible for Medicare (or cover a dependent who is eligible for Medicare). You will also receive a notice if **prescription** drug coverage is no longer offered under your Commonwealth of Virginia plan, or your coverage ceases to be creditable. You may also request a copy at any time.

For More information about Your Options

More detailed information about Medicare plans that offer **prescription** drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare **prescription** drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help,
- Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare **prescription** drug coverage is available. For more information, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY **1-800-325-0778**).

Remember

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October, 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your handbook or contact your Commonwealth of Virginia Benefits Administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer name
Commonwealth of Virginia
Department of Human Resource Management</td><td colspan="2">4. Employer Identification Number (EIN)
54-6024817</td></tr>
<tr><td colspan="2">5. Employer address
101 N. 14th Street, 12th Floor</td><td colspan="2">6. Employer phone number
1-888-642-4414 or 804-225-3624</td></tr>
<tr><td>7. City
Richmond</td><td>8. State
Virginia</td><td colspan="2">9. ZIP code
23219</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Virginia Department of Human Resource Management, Office of Health Benefits</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td colspan="2">12. Email address
ohb@dhrm.virginia.gov</td></tr>
</table>

Here is some basic information about health care coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees
  - √ Some employees. Eligible employees are:

    All full-time or part-time, salaried, classified state employees or regular, full-time or part-time, salaried faculty members; classified or similarly situated employees in legislative, executive, judicial or independent agencies who are compensated on a salaried basis. Part-time employees who work less than 32 hours per week must pay the entire cost of coverage.
- With respect to dependents:
  - √ We do offer coverage. Eligible dependents are:

    Spouse recognized as legally married in Virginia; natural or adopted son/daughter and stepson/stepdaughter to the end of the year in which he/she turns age 26. Special rules apply for other children and incapacitated adult dependents living in your household. See more at www.dhrm.virginia.gov/hbenefits/eligibilityrulesrev06302013.pdf
  - ☐ We do not offer coverage.

√ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or your work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

CHIPRA

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **1-866-444-EBSA** (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2014. You should contact your State for further information on eligibility.

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	IDAHO – Medicaid Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949

IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	NEBRASKA – Medicaid Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/ clientindex.shtml Phone: 1-800-694-3084	OREGON – Medicaid and CHIP Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
RHODE ISLAND – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300	VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820	WASHINGTON – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	WISCONSIN – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
UTAH – Medicaid and CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414	WYOMING – Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Other Federal Notices

Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective January 1, 2010, GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

The Newborns' and Mothers' Health Protection Act

Maternity **hospital** stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter stay if the attending provider (**physician**, nurse midwife or **physician**'s assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:

- The level of benefits for any portion of the **hospital** stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require **precertification** for a stay of up to 48 or 96 hours, as described above – although stays beyond those times must be precertified if the Plan includes a **precertification** requirement.

The Women's Health and Cancer Rights Act

When a woman who is covered by the Plan decides to have reconstructive surgery after a **medically necessary** mastectomy, the Women's Health and Cancer Rights Act requires the Plan to cover these procedures:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending **physician** and the patient.

For answers to questions about the Plan's coverage of mastectomies and reconstructive surgery, call Member Services at the number on your ID card.

USERRA Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the Plan for up to 24 months when they are called to active duty for more than 31 days.

You may continue plan coverage during your military leave until the earlier of:

- 24 months; or
- The date you fail to return to work as outlined by USERRA.

If you do not continue coverage for you or your family members during your leave and you return to work:

- You and your family members will again be covered on the first of the month following the date you return to work from your military leave, if you apply at that time (this requires you to return to work as outlined by USERRA);
- Any eligibility waiting period not completed earlier will not be credited during your leave.*

You will be given credit for the time you were covered under the plan before your military leave, as well as credit for any/all of the 24-month continuation period, when elected.

You are responsible for paying the employee cost for coverage during a military leave. If you fail to make timely payments, as outlined in your billing statement, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

*There is no waiting period under the Commonwealth of Virginia Health Benefits Program.

Definitions

This section defines the words and phrases in **bold type** that appear throughout the text of this book.

Allowable charge
The maximum amount that the Health Plan will recognize as a covered expense. Charges that exceed the **allowable charge** are not covered.

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

Appliance
This is a device used for functional or healing effect. A fixed **appliance** is cemented to the teeth or is attached by adhesive materials. A prosthetic **appliance** is used for replacing a missing tooth.

Behavioral health provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for the treatment of mental health and substance abuse. **Behavioral health provider**s include hospitals, psychiatric **physician**s, psychologists and social workers.

Bitewing
This is a dental X-ray showing approximately the **crown** halves of the upper and lower jaw.

Brand-name drug
A **prescription drug** that is protected by trademark registration.

Bridgework
A fixed bridge is a partial **denture** that is used as abutments, and is retained with **crowns** or **inlays** cemented to natural teeth. A fixed-removable bridge is a bridge that can be removed by a **dentist** but not by a patient. A removable bridge is a partial **denture** that is retained by attachments – usually clasps – that permit removal of the **denture**.

Claim administrator
For this Plan, it is Aetna.

Coinsurance
The percentage of covered expenses that you pay after the Plan pays its benefits. Your Plan at a Glance shows you the **coinsurance** that you pay and what the Plan pays for covered services.

Companion
This is a person who needs to be with an **NME patient** to enable him or her:

- To receive services in connection with an NME (National Medical Excellence) procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

Copay/copayment
This is a fee that you pay at the time you receive a covered service. Under this Plan, the Optional Expanded Vision Plan includes **copay**s for some services.

Crown
This is the portion of a tooth covered by enamel.

Custodial care
This means services and supplies, including **room and board** and other institutional care, provided to help you in the activities of daily life. You do not have to be disabled. Such services and supplies are **custodial care** no matter who prescribes, recommends or performs them. This Plan does not cover **custodial care**.

Deductible
This is the amount of covered expenses that a Plan participant must pay each **plan year** before the Plan begins paying benefits.

Dental hygienist
This is someone who has been trained to provide certain dental services, such as the removal of stains and deposits on the teeth.

Dentist
This means a legally qualified **dentist** or a **physician** licensed to do the dental work he or she performs.

Denture
This is a device that replaces missing teeth.

Directory
This is a listing of **in-network provider**s in the service area covered under the Plan. A current list of **in-network provider**s may be obtained from the Health Concierge at **1-855-414-1901** and is also available through Aetna's online provider **directory**, DocFind at **www.covahealthaware.com**.

Durable medical equipment
This is equipment – and the accessories needed to operate it – that is:

- Made to withstand prolonged use;
- Made for and used mainly in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to people who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

The Plan does not allow for more than one item of equipment for the same or similar purpose. **Durable medical equipment** does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

Effective treatment of alcohol or Substance Abuse
This means a program of alcohol or substance abuse therapy that is prescribed and supervised by a **behavioral health provider** and either:

- Has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- Includes meetings at least once a month with organizations devoted to the treatment of alcohol or substance abuse.

Note: Maintenance care (providing an alcohol- and/or drug-free environment) and detoxification are not considered "effective treatment."

Effective treatment of a Mental disorder
This is a program that:

- Includes a written treatment plan that is prescribed and supervised by a **behavioral health provider**;
- Includes follow-up treatment; and
- Is for a disorder that can be changed for the better.

Emergency admission
This means a **hospital** admission when the **physician** admits you to the **hospital** right after the sudden and, at that time, unexpected onset of a change in your physical or mental condition:

- That requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna) reasonably be expected to result in:
  - Placing your health in serious jeopardy; or
  - Serious impairment to bodily function; or
  - Serious dysfunction of a body part or organ; or
  - Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency care
This means the treatment given to you in a **hospital**'s emergency room to evaluate and treat medical conditions of recent onset and severity – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency condition
This means a recent and severe medical condition – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Endodontics
This is the study and treatment of the dental pulp. Endodontic services include **root canal therapy**.

Experimental and investigational
A drug, device, procedure or care is considered **experimental and investigational** if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- It does not have the approval required for marketing by the U.S. Food and Drug Administration; or
- A nationally recognized medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or

- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and U.S. Department of Health and Human Services; or
- The written protocol(s) or written informed consent used by the treating facility – or another facility studying the same drug, device, treatment or procedure – states that it is experimental, investigational or for research purposes.

Fluoride
This is a solution of fluorine that is applied to the surface of teeth to prevent tooth decay.

Generic drug
A **generic drug** is a **prescription** drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home health care agency
This is an agency that:

- Provides mainly skilled nursing and other therapeutic services; and
- Is associated with a professional group (of at least one **physician** and one **RN)** that makes policy; and
- Has full-time supervision by a **physician** or an **RN**; and
- Keeps complete medical records for each patient; and
- Has an administrator; and
- Meets licensing standards.

Home health care plan
This is a plan that provides for care and treatment in your home. It must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to inpatient **hospital** or **skilled nursing facility** care.

Hospice care
This is care provided to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice care agency
This is an agency or organization that:

- Has **hospice care** available 24 hours a day;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Provides:
  - Skilled nursing services; and
  - Medical social services; and
  - Psychological and dietary counseling;

- Provides, or arranges for, other services that include:
  - **Physician** services; and
  - Physical and occupational therapy; and
  - Part-time home health aide services that consist mainly of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- Has at least the following personnel:
  - One **physician**; and
  - One **RN**; and
  - One licensed or certified social worker employed by the agency;
- Establishes policies about how **hospice care** is provided;
- Assesses the patient's medical and social needs;
- Develops a **hospice care program** to meet those needs;
- Provides an ongoing quality assurance program, including reviews by **physician**s other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record for each patient;
- Uses volunteers trained in providing services for non-medical needs; and
- Has a full-time administrator.

Hospice care program
This is a written plan of **hospice care** that:

- Is established by and reviewed from time to time by your attending **physician** and appropriate **hospice care agency** personnel;
- Is designed to provide palliative (pain relief) and supportive care to **terminally ill** people and supportive care to their families; and
- Includes an assessment of your medical and social needs, and a description of the care to be given to meet those needs.

Hospital
This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons;
- Is supervised by a staff of **physician**s;
- Provides 24-hour-a-day **RN** service;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home; and
- Charges for its services.

Impression
This is a reproduction of a given area of a tooth.

Infertile or Infertility
A person is considered **infertile** if he or she is unable to conceive or produce conception after one year (6 months if the female partner is over age 35) of frequent, unprotected heterosexual sexual intercourse.

Inlay
This is a **restoration** that is:

- Made to fit a tooth cavity; and
- Cemented into place.

In-network care
This is a health care service or supply furnished by:

- An **in-network provider**; or
- A health care provider who is not an **in-network provider** when there is an **emergency condition** and travel to a provider in the network is not possible.

In-network pharmacy
A **pharmacy,** including a **mail-order pharmacy**, that has a contract with Aetna to dispense drugs to persons covered under this Plan, but only while:

- The contract remains in effect; and
- The **pharmacy** dispenses **prescription drugs** under the terms of its contract with Aetna.

In-network provider
This is a health care provider who has contracted to furnish services or supplies for a **negotiated charge**, but only if the provider is, with Aetna's consent, included in the **directory** as a preferred care provider for:

- The service or supply involved; and
- The class of employees to which you belong.

LPN
This means a licensed practical nurse.

Mail-Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail.

Medically Necessay
Health care services and supplies that a **physician**, other health care provider or **dentist**, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an **illness**, **injury** or disease. The service or supply must be:

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

For these purposes, "generally accepted standards of medical or dental practice" means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with **physician** or dental specialty society recommendations and the views of **physician**s or **dentist**s practicing in relevant clinical areas and any other relevant factors.

Mental disorder

This is a disease commonly understood to be a **mental disorder** whether or not it has a physiological or organic basis. Treatment for **mental disorder**s is usually provided by or under the direction of a **behavioral health provider** such as a psychiatrist, psychologist or psychiatric social worker. **Mental disorder**s include (but are not limited to):

- Alcohol and substance abuse
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

Morbid obesity

This means:

- Your body mass index (BMI) exceeds 40; or
- Your BMI exceeds 35 and you have one of the following conditions:
  - Coronary heart disease; or
  - Type 2 diabetes mellitus; or
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic, despite optimal medical management).

Body mass index (BMI) is a marker that is used to assess the degree of obesity. To calculate your BMI:

- Multiply your weight in pounds by 703.
- Divide the result by your height in inches.
- Divide that result by your height in inches again.

NME patient

This is a person who:

- Needs any of the National Medical Excellence (NME) program procedure and treatment types covered by the Plan; and
- Contacts Aetna and is approved by Aetna as an **NME patient**; and
- Agrees to have the procedure or treatment performed in a **hospital** that Aetna determines is the most appropriate facility.

Negotiated charge

This is the maximum fee an **in-network provider** has agreed to charge for any service or supply for the purpose of benefits under this Plan.

Non-occupational disease

A **non-occupational disease** is a disease that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be considered non-occupational regardless of its cause if proof is provided that you:

- Are covered under any type of workers' compensation law; and
- Are not covered for that disease under such law.

Non-occupational injury
A **non-occupational injury** is an accidental bodily injury that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-urgent admission
An admission that is not an **emergency admission** or an **urgent admission**.

Onlay
A **restoration** that covers the entire surface of a tooth (often used to restore a part of a tooth or to increase the height of a tooth).

Orthodontic treatment
This is any medical or dental service or supply, whether or not for the purpose of relieving pain, given to prevent, diagnose or correct a misalignment of:

- The teeth;
- The bite; or
- The jaws or jaw joint relationship;

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-network care
This is a health care service or supply provided by an **out-of-network provider** if, as determined by Aetna:

- The service or supply could have been provided by an **in-network provider**; and
- The provider does not belong to one or more of the provider categories in the **directory**.

Out-of-network provider
This is a health care provider who does not belong to Aetna's network and has not contracted with Aetna to furnish services or supplies at a **negotiated charge.**

Out-of-pocket maximum
The **out-of-pocket maximum** is the maximum that you must pay out of pocket for covered expenses each **plan year**.

Partial hospitalization
A medically supervised day, evening and/or night treatment program for mental health or substance abuse disorders. Care is coordinated by a multidisciplinary treatment team. Services are provided on an outpatient basis for at least four hours per day and are available at least three days per week. The services are of the same intensity and level as inpatient services for the treatment of behavioral health disorders.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified **physician**. The term "doctor" is also used throughout this book, and has the same meaning as "**physician**."

Plan year
The 12-month period that begins on July 1 and ends on June 30.

Precertification

This is a review of certain types of care to determine whether the proposed care is covered by the Plan. This review takes place before the care is given. **In-network provider**s will precertify services on behalf of the participant. If an **out-of-network provider** is used, the participant is encouraged to contact the Health Concierge to precertify services to ensure that they are covered. If a service is performed out-of-network and later determined not to be **medically necessary** or to be a non-covered service, the participant will be responsible for 100% of the cost of the service.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription** drug.

Prescription
A **prescriber**'s order for a **prescription** drug. If it is an oral order (such as a phoned-in **prescription**), it must be put in writing promptly by the **pharmacy**.

Prescription drugs
Any of the following:

- A drug, biological or compounded **prescription** that, by federal law, may be dispensed only by **prescription** and that is required to be labeled "Caution: Federal law prohibits dispensing without **prescription**."
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.
- An injectable drug prescribed to be self-administered or administered by another person except someone who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include insulin.
- Disposable needles and syringes purchased to administer a covered injectable **prescription** drug.
- Disposable diabetic supplies.

Preventive care
Services to help prevent illness. The Plan covers **preventive care** such as routine physical and well-child exams, immunizations and screenings for cancer. You can find more information about the Plan's coverage of **preventive care** in **Preventive care**.

Provider
Providers who may give care under this plan can include audiologists, certified nurse midwives (per plan provisions), chiropractors, chiropodists, clinical social workers, psychologists, clinical nurse specialists in psychiatric behavioral health, professional counselors, marriage and family therapists, dentists, doctors of medicine (including osteopaths and other specialists), occupational therapists, opticians, optometrists, podiatrists, registered physical therapists, retail health clinics and speech pathologists.

Psychiatric hospital
An institution that meets ***all*** of the following criteria:

- Mainly provides a program for the diagnosis, evaluation and treatment of **mental disorder**s or alcohol or substance abuse.
- Is not mainly a school or custodial, recreational or training institution.
- Provides infirmary-level medical services.
- Provides, or arranges with a **hospital** in the area to provide, any other medical service that may be needed.
- Is supervised full-time by a psychiatric **physician** who is responsible for patient care.
- Is staffed by psychiatric **physician**s involved in care and treatment.
- Has a psychiatric **physician** present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.

- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time **RN**.
- Prepares and maintains a written plan of treatment for each patient. The plan must be supervised by a psychiatric **physician**.
- Charges for its services.
- Meets licensing standards.

RN
This means a registered nurse.

Rebase
This is the process of refitting a **denture** by replacing the base material.

Recognized charge
The **recognized charge** is the lower of:

- The provider's usual charge to provide that service or supply; or
- The charge Aetna determines to be appropriate, based on factors such as:
  - The cost of supplying the same or a similar service or supply; and
  - The way charges for the service or supply are made, billed or coded.

  For non-facility charges: Aetna uses the 80th percentile of charges as reported in a database of charges that Aetna receives from a third party. Aetna may contribute information to that third party that is used in assembling the database.

  For facility charges: Aetna uses the charge Aetna determines to be the usual charge level for the service in the geographic area where the service is furnished.

Aetna may reduce the **recognized charge** to address the appropriate billing of services, taking into account factors such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and **necessary** for the service;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna's reimbursement policies are based on:

- Aetna's review of policies developed for Medicare;
- Generally accepted standards of medical and dental practice; and
- The views of **physician**s and **dentist**s practicing in the relevant clinical areas.

Aetna uses a commercial software package to administer some of these policies.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

Reline
This is the process of resurfacing the tissue side of a **denture** with new base material.

Restoration
This is any **restoration** of a tooth structure, tooth or oral tissue.

Room and board charges
Charges made by an institution for room and board and other **necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

Root canal therapy
The treatment of a tooth having a damaged pulp.

Scaling
This is the removal of tartar and stains from teeth.

Semi-private room rate
This is the **room and board charge** that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility
This is an institution that:

- Is licensed or approved under state or local law;
- Qualifies as a skilled nursing facility under Medicare, or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
  - Medical or nursing care; or
  - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an **RN**, or by an **LPN** directed by a full-time **RN**; and
  - Physical **restoration** services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time **RN**;
- Is supervised full-time by a **physician** or **RN**;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for people who are mentally retarded, or for custodial or educational care;
- Is not mainly a place for the care and treatment of alcoholism, substance abuse or **mental disorder**s, and
- Charges for its services.

A skilled nursing facility may be a rehabilitation **hospital** or a portion of a **hospital** designated for skilled or rehabilitation services.

Specialist
A **specialist** is a **physician** who practices in any generally accepted medical or surgical sub-specialty, and provides care that is not considered routine medical care.

Surgery center
This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.

- Charges for its services.
- Is directed by a staff of **physician**s, at least one of whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
- Extends surgical staff privileges to **physician**s who practice surgery in an area **hospital** and to **dentist**s who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an **RN**.
- Is equipped and has staff trained to handle medical emergencies.
- Must have a **physician** trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
- Has a written agreement with an area **hospital** for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program that includes reviews by **physician**s who do not own or direct the facility.
- Keeps a medical record for each patient.

Terminally ill
This is a medical prognosis of 12 months or fewer to live.

Urgent admission
An **urgent admission** is one in which the **physician** admits you to the **hospital** because of:

- The onset of, or change in, a disease; or
- The diagnosis of a disease; or
- An injury caused by an accident.

An **urgent admission**, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within two weeks from the date the need for confinement becomes apparent.

Urgent Care Provider
This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an **urgent condition** if your **physician** is not reasonably available;
- Routinely provides ongoing unscheduled medical services for more than eight consecutive hours;
- Charges for services;
- Is licensed and certified as required by state or federal law or regulation;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by **physician**s other than those who own or run the facility;
- Is run by a staff of **physician**s, with one **physician** on call at all times; and
- Has a full-time administrator who is a **physician**.

An urgent care provider may also be a **physician**'s office if it has contracted with Aetna to provide urgent care and is, with Aetna's consent, included in its provider **directory** as an in-network urgent care provider.

A **hospital** emergency room or outpatient department is not considered to be an urgent care provider.

Urgent condition

This is a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems;
- Includes a condition that could cause you severe pain that cannot be managed without urgent care or treatment;
- Does not require the level of care provided in a **hospital** emergency room; and
- Requires immediate outpatient medical care that can't be postponed until your **physician** becomes reasonably available.

Walk-in clinic

A free-standing health care facility that:

- Treats unscheduled and/or non-emergency illnesses and injuries; and
- Administers certain immunizations.

A **walk-in clinic** must:

- Provide unscheduled and/or non-emergency medical services;
- Make charges for the services provided;
- Be licensed and certified as required by any state or federal law or regulation;
- Be staffed by independent practitioners, such as Nurse Practitioners, licensed in the state where the clinic is located;
- Keep a medical record on each patient;
- Provide an ongoing quality assurance program;
- Have at least one **physician** on call at all times;
- Have a **physician** who sets protocol for clinical policies, guidelines and decisions; and
- Not be the emergency room or outpatient department of a **hospital**.