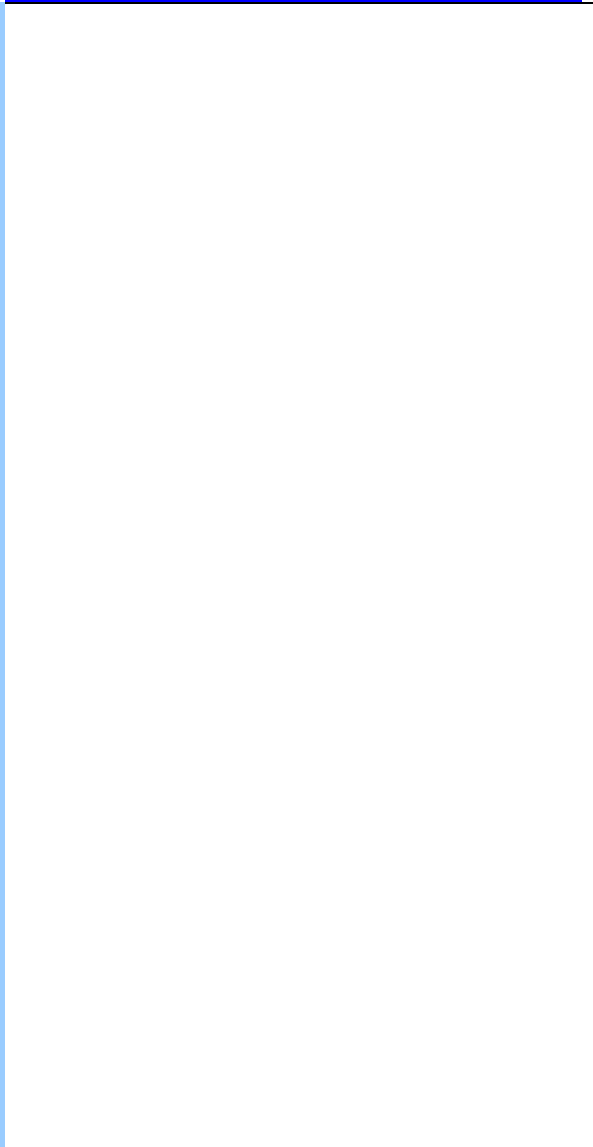


# **BENEFIT PLAN**

**Prepared Exclusively for  
The McClatchy Company**

**Aetna Savings Advantage Plan – Actives**

**What Your Plan  
Covers and How  
Benefits are Paid**





**Choice POS II Medical Plan**

**Booklet**

**Prepared exclusively for:**

**Employer:** The McClatchy Company

**Contract number:** 620229

Booklet 2

**Plan effective date:** January 1, 2019

**Plan issue date:** January 1, 2019

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

# Welcome

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Thank you for choosing **Aetna**.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

This booklet will tell you about your **covered benefits** – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for **eligible health services** and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they're part of.

Where to next? Flip through the table of contents or try the *Let's get started!* section right after it. The *Let's get started!* section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer's self-funded health benefit plan for in-network and out-of-network coverage.

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Schedule of benefits

Included with your booklet-

# Let's get started!

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Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

## Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean **Aetna** when we are describing administrative services provided by **Aetna** as Third Party Administrator.
- Some words appear in **bold** type. We define them in the *Glossary* section.

Sometimes we use technical medical language that is familiar to medical **providers**.

## What your plan does – covered benefits

Your plan provides **covered benefits**. These are **eligible health services** for which your plan has the obligation to pay.

This plan provides in-network and out-of network coverage for medical, vision and pharmacy benefits.

## What your plan doesn't do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described more in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the *Eligible health services under your plan* section. However, some of those health care services and supplies have exclusions. For example, **physician care** is an eligible health service, but **physician care** for cosmetic surgery is never covered. This is an example of an exclusion.

The *What your plan doesn't cover - some eligible health service exclusions* section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

## How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the *Who the plan covers* section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

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

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called **eligible health services**.
- You will pay less cost share when you use a **network provider**.

### 1. Eligible health services

Doctor and **hospital** services are the foundation for many other services. You'll probably find the preventive care, **emergency services** and **urgent condition** coverage especially important. But the plan won't always cover the services you want. Sometimes it doesn't cover health care services your doctor will want you to have.

So what are **eligible health services**? They are health care services that meet these three requirements:

- They are listed in the *Eligible health services under your plan* section.
- They are not carved out in the *What your plan doesn't cover – some eligible health service exclusions* section. (We refer to this section as the "exclusions" section.)
- They are not beyond any limits in the schedule of benefits.

### 2. Providers

**Aetna's** network of doctors, **hospitals** and other health care **providers** are there to give you the care you need. You can find **network providers** and see important information about them most easily on our online **provider directory**. Just log into your Aetna member website at [www.aetna.com](http://www.aetna.com).

You may choose a **primary care physician** (we call that doctor your **PCP**) to oversee your care. Your **PCP** will provide your routine care, and send you to other **providers** when you need specialized care. You don't have to access care through your **PCP**. You may go directly to network **specialists** and **providers** for **eligible health services**. Your plan often will pay a bigger share for **eligible health services** that you get through your **PCP**, so choose a **PCP** as soon as you can.

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

### 3. Paying for eligible health services– the general requirements

There are several general requirements for the plan to pay any part of the expense for an **eligible health service**. They are:

- The **eligible health service** is **medically necessary**.
- You get the **eligible health service** from a **network** or **out-of-network provider**.
- You or your **provider precertifies** the **eligible health service** when required.

You will find details on **medical necessity** and **precertification** requirements in the *Medical necessity and precertification requirements* section.

### 4. Paying for eligible health services– sharing the expense

Generally your plan and you will share the expense of your **eligible health services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section, and see the schedule of benefits.

## 5. Disagreements

We know that people sometimes see things differently.

The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “external review organization” or ERO for short, will make the final decision for us.

For more information see the *When you disagree - claim decisions and appeals procedures* section.

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

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from **providers** who are not part of the **Aetna** network. It’s called out-of-network or **other health care** coverage.

Your out-of-network coverage:

- Means you can get care from **providers** who are not part of the **Aetna** network.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible health services** that you paid directly to a **provider**.
- Means that when you use out-of-network coverage, it is your responsibility to start the **precertification** process with **providers**.
- Means you will pay a higher cost share when you use an **out-of-network provider**.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

## How to contact us for help

We are here to answer your questions. You can contact us by logging onto your Aetna member website at [www.aetna.com](http://www.aetna.com).

Register for Aetna’s member website, our secure internet access to reliable health information, tools and resources. Aetna’s member website online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can also contact us by:

- Calling **Aetna** Member Services at the toll-free number on your ID card
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156



## **Your member ID card**

Your member ID card tells doctors, **hospitals**, and other **providers** that you are covered by this plan. Show your ID card each time you get health care from a **provider** to help them bill us correctly and help us better process their claims.

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

We will mail you your ID card. If you haven't received it before you need **eligible health services**, or if you've lost it, you can print a temporary ID card. Just log into your Aetna member website at [www.aetna.com](http://www.aetna.com).

## Who the plan covers

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You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

### Who is eligible

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

### When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period your Employer requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join.

### Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet as your “dependents”.)

- Your spouse
- Your domestic partner who meets the rules set by the employer and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
  - The children must be under 26 years of age, and they include your:
    - Biological children
    - Stepchildren
    - Legally adopted children, including any children placed with you for adoption
    - Foster children,
    - Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    - Grandchildren in your court-ordered custody
    - Any other child with whom you have a parent-child relationship

You may continue coverage for a disabled child past the age limit shown above. See the *Continuation of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

### Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.

- Ask your Employer when benefits for your spouse will begin. It will be:
  - o No later than the first day of the first calendar month after the date your Employer receives your completed enrollment information and
  - o Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your health plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by your Employer.
  - Ask your Employer when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.
- A newborn child - Your newborn child is not automatically covered on your health plan.
  - Your Employer must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits.
- An adopted child - A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption.
  - Proof of placement will need to be presented to your Employer prior to the dependent enrollment;
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
- A stepchild - You may put a child of your spouse or domestic partner on your plan.
  - You must complete your enrollment information and send it to your Employer within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
  - Ask your Employer when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date your Employer receives your completed enrollment information.

### **Notification of change in status**

It is important that you notify your Employer of any changes in your benefit status. This will help your Employer effectively maintain your benefit status. Please notify your employer as soon as possible of status changes such as:

- Change of address
- Change of covered dependent status
- Enrollment in Medicare or any other group health plan of any covered dependent

### **Special times you and your dependents can join the plan**

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your contribution for coverage under this plan.
- When a court orders that you cover a current spouse or domestic partner or a minor child on your health plan.

Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

**Effective date of coverage**

Your coverage begins on the date your employer tells us. This will be the effective date on the enrollment information sent to us to enroll you and your eligible dependents in the plan.

Claims will not be paid under any health benefits for expenses incurred in connection with any hospital stay that began before the date you or your dependents became covered.

## Medical necessity and precertification requirements

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The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible health services**. See the *Eligible health services under your plan and exclusions* sections plus the schedule of benefits.

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

- The **eligible health service** is **medically necessary**.
- You or your **provider** **precertifies** the **eligible health service** when required.

This section addresses the **medical necessity** and **precertification** requirements.

### Medically necessary; medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are stated in the *Glossary* section, where we define "**medically necessary, medical necessity**". That is where we also explain what our medical directors or their **physician** designees consider when determining if an **eligible health service** is **medically necessary**.

### Precertification

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

**In-network:** your **physician** is responsible for obtaining any necessary **precertification** before you get the care. If your **physician** doesn't get a required **precertification**, we won't pay the **provider** who gives you the care. You won't have to pay either if your **physician** fails to ask us for **precertification**. If your **physician** requests **precertification** and we refuse it, you can still get the care but the plan won't pay for it. You will find details on requirements in the *What the plan pays and what you pay - Important exceptions – when you pay all* section.

**Out-of-network:** when you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from us for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring **precertification** appears later in this section. Also, for any **precertification** benefit reduction that is applied see the schedule of benefits *Precertification benefit reduction* section.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, **precertification** should be secured within the timeframes specified below. To obtain **precertification**, call us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your <b>physician</b> or the facility will need to call and request <b>precertification</b> at least 14 days before the date you are scheduled to be admitted.
For an <b>emergency admission</b> :	You, your <b>physician</b> or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.

For an <b>urgent admission</b> :	You, your <b>physician</b> or the facility will need to call before you are scheduled to be admitted. An urgent admission is a <b>hospital</b> admission by a <b>physician</b> due to the onset of or change in an <b>illness</b> , the diagnosis of an <b>illness</b> , or an <b>injury</b> .
For outpatient non-emergency medical services requiring <b>precertification</b> :	You or your <b>physician</b> must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your **physician** of the **precertification** decision, where required by state law. If your **precertified** services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, we will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be **precertified**. You, your **physician**, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. We will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered benefits**, the notification will explain why and how our decision can be appealed. You or your **provider** may request a review of the **precertification** decision. See the *Claim decisions and appeals procedures* section.

**What if you don't obtain the required precertification?**

If you don't obtain the required **precertification**:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Precertification benefit reduction* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network **deductibles** or **maximum out-of-pocket limits**.

**What types of services require precertification?**

**Precertification** is required for the following types of services and supplies:

<b>Inpatient services and supplies</b>
<b>Stays in a hospital</b>
<b>Stays in a skilled nursing facility</b>
<b>Stays in a rehabilitation facility</b>
<b>Stays in a hospice facility</b>
<b>Stays in a residential treatment facility for treatment of mental disorders and substance abuse</b>
Bariatric surgery (obesity)
Cosmetic and reconstructive surgery

Certain **prescription drugs** are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a **pharmacy**. The following **precertification** information applies to these **prescription drugs**:

For certain drugs, your **prescriber** or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a **medically necessary** need for the drug. For the most up-to-date information, call the toll-free Member Services number on your member ID card or log on to your Aetna member website at [www.aetna.com](http://www.aetna.com).

There is another type of **precertification** for **prescription drugs**, and that is **step therapy**. **Step therapy** is a type of **precertification** where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can obtain the most up-to-date information about **step therapy prescription drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna member website at [www.aetna.com](http://www.aetna.com). Your doctor can find additional details about the **step therapy prescription drugs** in our clinical policy bulletins.

Sometimes you or your **prescriber** may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through **precertification and/or step therapy**. You or your **prescriber** can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.

## Eligible health services under your plan

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The information in this section is the first step to understanding your plan's **eligible health services**.

Your plan covers many kinds of health care services and supplies, such as **physician** care and **hospital stays**. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- **Physician** care generally is covered but **physician** care for **cosmetic** surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered benefit** only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the *exclusions* section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

### Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

#### Important notes:

1. You will see references to the following recommendations and guidelines in this section:

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

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

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.

3. Gender-specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card. This information can also be found at the [www.HealthCare.gov](http://www.HealthCare.gov) website.



## Routine physical exams

**Eligible health services** include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.

## Preventive care immunizations

**Eligible health services** include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

## Well woman preventive visits

**Eligible health services** include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

## Preventive screening and counseling services

**Eligible health services** include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**  
**Eligible health services** include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling

- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

**Eligible health services** include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

**Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;
- Tobacco cessation prescription and over-the-counter drugs
  - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

**Eligible health services** include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

**Eligible health services** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

## **Routine cancer screenings**

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a **network provider** who is an OB, GYN or OB/GYN.

## Prenatal care

**Eligible health services** include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's, PCP's, OB's, GYN's, or OB/GYN's** office.

### Important note:

You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

## Comprehensive lactation support and counseling services

**Eligible health services** include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

## Breast feeding durable medical equipment

**Eligible health services** include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

### Breast pump

**Eligible health services** include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

### Breast pump supplies and accessories

**Eligible health services** include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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

## Family planning services – female contraceptives

**Eligible health services** include family planning services such as:

### Counseling services

**Eligible health services** include counseling services provided by a **physician, PCP, OB, GYN, or OB/GYN** on contraceptive methods. These will be covered when you get them in either a group or individual setting.

### Devices

**Eligible health services** include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

### Voluntary sterilization

**Eligible health services** include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

#### Important note:

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

## Physicians and other health professionals

### Physician services

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

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

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

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

## Physician surgical services

**Eligible health services** include the services of:

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

### **Important note:**

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

## Alternatives to physician office visits

### **Walk-in clinic**

**Eligible health services** include health care services provided in **walk-in clinics** for:

- Unscheduled, non-medical emergency **illnesses** and **injuries**
- The administration of immunizations administered within the scope of the clinic's license

## Hospital and other facility care

### Hospital care

**Eligible health services** include inpatient and outpatient **hospital** care.

The types of **hospital** care services that are eligible for coverage include:

- **Room and board** charges up to the **hospital's semi-private room rate**. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of **physicians** employed by the **hospital**.
- Operating and recovery rooms.
- Intensive or special care units of a **hospital**.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a **hospital**.

### Alternatives to hospital stays

#### Outpatient surgery and physician surgical services

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

**Important note:**

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

### Home health care

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

- You are homebound.
- Your **physician** orders them.
- The services take the place of your needing to **stay** in a **hospital** or a **skilled nursing facility**, or needing to receive the same services outside your home.
- The services are a part of a **home health care plan**.
- The services are **skilled nursing services**, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a **physician** or social worker.

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

Home health care services do not include **custodial care**.

## Hospice care

**Eligible health services** include inpatient and outpatient **hospice care** when given as part of a **hospice care program**.

The types of hospice care services that are eligible for coverage include:

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

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

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

## Outpatient private duty nursing

**Eligible health services** include private duty nursing care provided by an **R.N.** or **L.P.N.** for non-hospitalized acute **illness** or **injury** if your condition requires skilled nursing care and visiting nursing care is not adequate.

## Skilled nursing facility

**Eligible health services** include inpatient **skilled nursing facility** care.

The types of **skilled nursing facility** care services that are eligible for coverage include:

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

## Emergency services and urgent care

**Eligible health services** include services and supplies for the treatment of an **emergency medical condition** or an **urgent condition**.

As always, you can get emergency care from **network providers**. However, you can also get emergency care from **out-of-network providers**.

Your coverage for **emergency services** and urgent care from **out-of-network providers** ends when **Aetna** and the attending **physician** determine that you are medically able to travel or to be transported to a **network provider** if you need more care.

As it applies to in-network coverage, you are covered for follow-up care only when your **physician or PCP** provides or coordinates it. If you use an **out-of-network provider** to receive follow up care, you are subject to a higher out-of-pocket expense.

## In case of a medical emergency

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your **physician or PCP** but only if a delay will not harm your health.

## Non-emergency condition

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits and the *exclusion- Emergency services and urgent care and Precertification benefit reduction* sections for specific plan details.

## In case of an urgent condition

### Urgent condition

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

### Non-urgent care

If you go to an **urgent care facility** for what is not an **urgent condition**, the plan may not cover your expenses. See the *exclusion –Emergency services and urgent care and Precertification covered benefit reduction* sections and the schedule of benefits for specific plan details.



## Specific conditions

### Autism spectrum disorder

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

**Eligible health services** include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

### Birthing center

**Eligible health services** include prenatal and postpartum care and obstetrical services from your **provider**. After your child is born, **eligible health services** include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

### Diabetic equipment, supplies and education

**Eligible health services** include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Insulin preparations
  - Diabetic needles and syringes
  - Injection aids for the blind
  - Diabetic test agents
  - Lancets/lancing devices
  - Prescribed oral medications whose primary purpose is to influence blood sugar
  - Alcohol swabs
  - Injectable glucagons
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care **provider** certified in diabetes self-management training

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

### Family planning services – other

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

- Voluntary sterilization for males
- Abortion

## Jaw joint disorder treatment

**Eligible health services** include the diagnosis and surgical treatment of **jaw joint disorder** by a **provider** which includes:

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

## Maternity and related newborn care

**Eligible health services** include prenatal and postpartum care and obstetrical services. After your child is born, **eligible health services** include:

- 48 hours of inpatient care in a **hospital** after a vaginal delivery
- 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a **provider**.

## Mental health treatment

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

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

## Substance related disorders treatment

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

- **Inpatient room and board** at the **semi-private room rate**, and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital** or **residential treatment facility**. Treatment of **substance abuse** in a general medical **hospital** is only covered if you are admitted to the **hospital's** separate **substance abuse** section or unit, unless you are admitted for the treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group and family therapies for the treatment of **substance abuse**
  - Other outpatient **substance abuse** treatment such as:
    - Outpatient detoxification
    - **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications
    - Treatment of withdrawal symptoms
    - Substance use disorder injectables
    - 23 hour observation

## Obesity surgery

**Eligible health services** include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the *Outpatient prescription drugs* section

Health care services include one obesity surgical procedure. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

You may go to any of our **network** facilities that perform obesity surgeries.

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

**Eligible health services** include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a **physician**, a dentist and **hospital**:

- Non-surgical treatment of infections or diseases.
- **Surgery** needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- **Hospital** services and supplies received for a **stay** required because of your condition.
- Dental work, **surgery** and **orthodontic treatment** needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your **injury**.
  - Other body tissues of the mouth fractured or cut due to **injury**.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of **orthodontic treatment** after an **injury**.

## **Reconstructive surgery and supplies**

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes **surgery** on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the **surgery** is to improve function.
- Your **surgery** is needed because treatment of your **illness** resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

## Transplant services

**Eligible health services** include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

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

## Network of transplant facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An **Institutes of Excellence™ (IOE) facility** we designate to perform the transplant you need
- A Non-IOE facility

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The National Medical Excellence Program® will coordinate all solid organ, bone marrow and CAR-T and T-Cell therapy services and other specialized care you need.

### Important note:

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

## Treatment of infertility

### Basic infertility

**Eligible health services** include seeing a **network provider**:

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

## Specific therapies and tests

### Outpatient diagnostic testing

#### Diagnostic complex imaging services

**Eligible health services** include complex imaging services by a **provider**, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

#### Diagnostic lab work and radiological services

**Eligible health services** include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

### Chemotherapy

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

### Outpatient infusion therapy

**Eligible health services** include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a **hospital**
- A **physician** in the office
- A home care **provider** in your home

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

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

### Outpatient radiation therapy

**Eligible health services** include the following radiology services provided by a **health professional**:

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

## Specialty prescription drugs

Eligible health services include specialty prescription drugs when they are:

- Purchased by your **provider**, and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home
- And, listed on our **specialty prescription drug** list as covered under this booklet.

You can access the list of **specialty prescription drugs** by contacting Member Services by logging onto your Aetna member website at [www.aetna.com](http://www.aetna.com) or calling the number on your ID card to determine if coverage is under the outpatient **prescription drug** benefit or this booklet.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable **home health care** maximums.

## Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

### Cardiac rehabilitation

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

### Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if it is part of a treatment plan ordered by your **physician**.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a **hospital, skilled nursing facility, or physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

## Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital, skilled nursing facility, or hospice facility**
- A **home health care agency**
- A **physician**

Short-term rehabilitation services have to follow a specific treatment plan.

## Outpatient cognitive rehabilitation, physical, occupational, speech therapy and neurodevelopmental therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness, injury or surgical procedure**.

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury or surgical procedure**, or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury or surgical procedure**, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.
- Neurodevelopmental Therapy for a covered dependent child to age 6. Treatment includes speech therapy, physical therapy or occupational therapy given to restore or improve a speech or body function; or to develop a speech or body function delayed by an illness or a congenital abnormality; or to maintain a speech or body function if, without therapy, an illness or congenital abnormality would cause significant deterioration in the child's condition.



## Other services

### Acupuncture

**Eligible health services** include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered **surgical procedure** and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache
  - Pain from osteoarthritis of the knee or hip (adjunctive therapy).

### Ambulance service

**Eligible health services** include transport by professional ground **ambulance** services:

- To the first **hospital** to provide **emergency services**.
- From one **hospital** to another **hospital** if the first **hospital** cannot provide the **emergency services** you need.
- From a **hospital** to your home or to another facility if an **ambulance** is the only safe way to transport you.
- From your home to a **hospital** if an **ambulance** is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a **hospital** by professional air or water **ambulance** when:

- Professional ground **ambulance** transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one **hospital** to another and
  - The first **hospital** cannot provide the **emergency services** you need, and
  - The two conditions above are met.

### Clinical trial therapies (experimental or investigational)

**Eligible health services** include **experimental or investigational** drugs, devices, treatments or procedures from a **provider** under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

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

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial 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 federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

## Clinical trials (routine patient costs)

**Eligible health services** include "routine patient costs" incurred by you from a **provider** in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

## Durable medical equipment (DME)

**Eligible health services** include the expense of renting or buying **DME** and accessories you need to operate the item from a **DME** supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase **DME**, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of **DME** for the same or similar purpose.
- Repairing **DME** due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new **DME** item you need because your physical condition has changed. It also covers buying a new **DME** item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Your plan only covers the same type of **DME** that Medicare covers. But there are some **DME** items Medicare covers that your plan does not. We list examples of those in the *exclusions* section.

## Hearing aids and exams

**Eligible health services** include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

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

Hearing aid services are:

- Audiometric hearing exam and evaluation for a hearing aid **prescription** performed by:
  - A **physician** certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

## **Non-routine/non-preventive care hearing exams**

**Eligible health services** for adults and children include charges for an audiometric hearing exam for evaluation and treatment of **illness, injury** or hearing loss, if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist
- An audiologist who is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

## **Prosthetic devices**

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

Prosthetic device means:

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

Coverage includes:

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

## **Spinal manipulation**

**Eligible health services** include spinal manipulation to correct a muscular or skeletal problem, but only if your **provider** establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

## Outpatient prescription drugs

### Preventive contraceptives

For females who are able to reproduce, your plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing. Your outpatient **prescription drug** plan also covers related services and supplies needed to administer covered devices. At least one form of contraception in each of the methods identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your Aetna member website at [www.aetna.com](http://www.aetna.com) or calling the number on your ID card.

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

**Important Note:** You may qualify for a medical exception if your **provider** determines that the contraceptives covered standardly as preventive are not medically appropriate. Your **prescriber** may request a medical exception and submit the exception to us.

### Preventive care drugs and supplements

**Eligible health services** include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the Affordable Care Act (ACA) guidelines when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

### Risk reducing breast cancer prescription drugs

**Eligible health services** include **prescription drugs** used to treat people who are at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

### Tobacco cessation prescription and over-the-counter drugs

**Eligible health services** include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

### What outpatient prescription drugs are covered

Your **prescriber** may give you a **prescription** in different ways, including:

- Writing out a **prescription** that you then take to a **network pharmacy**
- Calling or e-mailing a **network pharmacy** to order the medication
- Submitting your **prescription** electronically

Once you receive a **prescription** from your **prescriber**, you may fill the **prescription** at a **network, retail, mail order** or **specialty pharmacy**.

## Exclusions: What your plan doesn't cover

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We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. And we told you there, that some of those health care services and supplies have exclusions. For example, **physician** care is an **eligible health service** but **physician** care for **cosmetic surgery** is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

- Under "General exclusions" we've explained what general services and supplies are not covered under the entire plan.
- Below the general exclusions, in "Exclusions under specific types of care," we've explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

### General exclusions

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

Examples of these are:

- The provision of blood to the **hospital**, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

#### Cosmetic services and plastic surgery

- Any treatment, **surgery (cosmetic or plastic)**, service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to **surgery** after an accidental **injury** when performed as soon as medically feasible. **Injuries** that occur during medical treatments are not considered accidental **injuries**, even if unplanned or unexpected.

#### Counseling

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

#### Court-ordered services and supplies

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

#### Custodial care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy

- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

**Dental care** except as covered in the *Eligible health services under your plan* Oral and maxillofacial treatment section.

Dental services related to:

- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts

### **Early intensive behavioral interventions**

Examples of those services are:

- Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

### **Educational services**

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment program, job training and job hardening programs
- Services provided by a school district.

### **Examinations**

Any health examinations needed:

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

## **Experimental or investigational**

- **Experimental or investigational** drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (**experimental or investigational**) or covered under clinical trials (routine patient costs). See the *Eligible health services under your plan – Other services* section.

## **Facility charges**

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

## **Foot care**

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

## **Growth/height care**

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

## **Maintenance care**

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function.

## **Medical supplies – outpatient disposable**

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

### **Other primary payer**

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

### **Outpatient prescription or non-prescription drugs and medicines**

- Outpatient **prescription** or non-**prescription drugs** and medicines provided by the employer or through a third party vendor contract with the employer.

### **Personal care, comfort or convenience items**

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

### **Pregnancy charges**

- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the *Eligible health services under your plan* section

### **Routine exams**

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Eligible health services under your plan* section

### **Services provided by a family member**

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

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

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

### **Sex change**

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

### **Sexual dysfunction and enhancement**

- Any treatment, **prescription drug**, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - **Surgery, prescription drugs**, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

### **Strength and performance**

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance



## Telemedicine

- Services given by **providers** that are not contracted with **Aetna** as **telemedicine providers**
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

## Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

## Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

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

- Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

## Vision care

- Vision care services and supplies, including:
  - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
  - Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

## Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

## Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar

law. If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered “non-occupational” regardless of cause.

## **Additional exclusions for specific types of care**

### **Preventive care and wellness**

- Services for diagnosis or treatment of a suspected or identified **illness** or **injury**
- Exams given during your **stay** for medical care
- Services not given by or under a **physician’s** direction
- Psychiatric, psychological, personality or emotional testing or exams

### **Family planning services**

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the **provider** or were not the primary purpose of a confinement.

### **Physicians and other health professionals**

There are no additional exclusions specific to **physicians** and other **health professionals**.

### **Hospital and other facility care**

### **Alternatives to facility stays**

#### **Outpatient surgery and physician surgical services**

- The services of any other **physician** who helps the operating **physician**
- A **stay** in a **hospital** (**Hospital stays** are covered in the *Eligible health services under your plan – Hospital and other facility care* section.)
- A separate facility charge for **surgery** performed in a **physician’s** office
- Services of another **physician** for the administration of a local anesthetic

#### **Home health care**

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

#### **Hospice care**

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation

- Maintenance of the house

### **Outpatient private duty nursing**

(See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

## **Specific conditions**

### **Family planning services - other**

- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

### **Maternity and related newborn care**

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

### **Mental health treatment**

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association):
  - Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders, except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

### **Obesity (bariatric) surgery**

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

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

- Dental implants

## Transplant services

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

## Treatment of infertility

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm from a person not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery).

## Specific therapies and tests

### Outpatient infusion therapy

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

### Specialty prescription drugs

- **Specialty prescription drugs** and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of **specialty prescription drugs** as covered under your outpatient **prescription drug** plan.

## Short-term rehabilitation services

### Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Autism Spectrum Disorder
  - Down syndrome
  - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

## Other services

### Ambulance services

- Fixed wing air ambulance from an **out-of-network provider**

### Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the *Eligible health services under your plan - Clinical trial therapies (experimental or investigational)* section.

### Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

### Durable medical equipment (DME)

Examples of these items are:

- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

## Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a **physician** who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

## Nutritional supplements

- Any food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Other services* section.

## Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

## Outpatient prescription drugs

### Preventive contraceptives

**Brand-name prescription drug** forms of contraception in each of the methods identified by the FDA

## Who provides the care

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Just as the starting point for coverage under your plan is whether the services and supplies are **eligible health services**, the foundation for getting covered care is the network. This section tells you about **network** and **out-of-network providers**.

### Network providers

We have contracted with **providers** to provide **eligible health services** to you. These **providers** make up the network for your plan. For you to receive the network level of benefits you must use **network providers** for **eligible health services**. There are some exceptions:

- **Emergency services** – refer to the description of **emergency services** and urgent care in the *Eligible health services under your plan* section
- **Urgent care** – refer to the description of emergency services and urgent care in the *Eligible health services under your plan* section

You may select a **network provider** from the **directory** through your Aetna member website at [www.aetna.com](http://www.aetna.com). You can search our online **directory**, provider search, for names and locations of **providers**.

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

### Your PCP

We encourage you to access **eligible health services** through a **PCP**. They will provide you with primary care.

A **PCP** can be any of the following **providers** available under your plan:

- General practitioner
- Family **physician**
- Internist
- Pediatrician

### How do you choose your PCP?

You can choose a **PCP** from the list of **PCPs** in our **directory**. See the *Who provides the care, Network providers* section.

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

### What will your PCP do for you?

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

Your **PCP** can also:

- Order lab tests and radiological services.
- Prescribe medicine or therapy.
- Arrange a **hospital stay** or a **stay** in another facility.

### How do I change my PCP?

You may change your **PCP** at any time. You can call us at the toll-free number on your ID card or log on to your Aetna member website at [www.aetna.com](http://www.aetna.com) to make a change.

## Out-of-network providers

You also have access to **out-of-network providers**. This means you can receive **eligible health services** from an **out-of-network provider**. If you use an **out-of-network provider** to receive **eligible health services**, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network **deductible**
- Your out-of-network **payment percentage**
- Any charges over our **recognized charge**
- Submitting your own claims and getting **precertification**

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

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

- You join the plan and the **provider** you have now is not in the network.
- You are already a member of **Aetna** and your **provider** stops being in our network.

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

	<b>If you are a new enrollee and your provider is an out-of-network provider</b>	<b>When your provider stops participation with Aetna</b>
Request for approval	You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card.	You or your <b>provider</b> should call <b>Aetna</b> for approval to continue any care.
Length of transitional period	Care will continue during a transitional, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the <b>provider</b> terminated their participation with <b>Aetna</b> .

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

We will authorize coverage for the transitional period only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

## What the plan pays and what you pay

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Who pays for your **eligible health services** – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **copayments/payment percentage**
- Your **maximum out-of-pocket limit**

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an **eligible health service**.



## The general rule

When you get **eligible health services**:

- You pay for the entire expense up to any **deductible** limit.

And then

- The plan and you share the expense up to any **maximum out-of-pocket limit**. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a **copayment/ payment percentage**.

And then

- The plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and the **recognized charge** for an **out-of-network provider**. See the *Glossary* section for what these terms mean.

## Important exception – when your plan pays all

Under the in-network level of coverage, your plan pays the entire expense for all **eligible health services** under the preventive care and wellness benefit.

## Important exceptions – when you pay all

You pay the entire expense for an **eligible health service**:

- When you get a health care service or supply that is not **medically necessary**. See the *Medical necessity and precertification requirements* section.
- When your plan requires **precertification**, your **physician** requested it, we refused it, and you get an **eligible health service** without **precertification**. See the *Medical necessity and precertification requirements* section.

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

## Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the **negotiated charge**

## Where your schedule of benefits fits in

### How your deductible works

Your **deductible** is the amount you need to pay, after paying your **copayment** or **payment percentage**, for **eligible health services** per Calendar Year as listed in the schedule of benefits. Your **copayment** or **payment percentage** does not count toward your **deductible**.

### **How your copayment/ payment percentage works**

Your **copayment/payment percentage** is the amount you pay for **eligible health services** after you have paid your **deductible**. Your schedule of benefits shows you which **copayments/payment percentage** you need to pay for specific **eligible health services**.

You will pay the **physician, PCP copayment/payment percentage** when you receive **eligible health services** from any **PCP**.

### **How your maximum out-of-pocket limit works**

You will pay your **deductible** and **copayments/payment percentage** up to the **maximum out-of-pocket limit** for your plan. Your schedule of benefits shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered benefits** for the remainder of that **Calendar Year**.

#### **Important note:**

See the schedule of benefits for any **deductibles, copayments/ payment percentage, maximum out-of-pocket limit** and maximum age, visits, days, hours, admissions that may apply.

## Claim decisions and appeals procedures

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In the previous section, we explained how you and the plan share responsibility for paying for your **eligible health services**.

When a claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

### Claim procedures

For claims involving **out-of-network providers**:

Notice	Requirement	Deadline
Submit a claim	<ul style="list-style-type: none"> <li>You should notify and request a claim form from your employer.</li> <li>The claim form will provide instructions on how to complete and where to send the form(s).</li> </ul>	<ul style="list-style-type: none"> <li>Within 15 working days of your request.</li> <li>If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.</li> </ul>
Proof of loss (claim)	<ul style="list-style-type: none"> <li>A completed claim form and any additional information required by your employer.</li> </ul>	<ul style="list-style-type: none"> <li>No later than 90 days after you have incurred expenses for <b>covered benefits</b>.</li> <li>We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.</li> <li>Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.</li> </ul>

Benefit payment	<ul style="list-style-type: none"> <li>• Written proof must be provided for all benefits.</li> <li>• If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.</li> </ul>	<ul style="list-style-type: none"> <li>• Benefits will be paid as soon as the necessary proof to support the claim is received.</li> </ul>
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## Types of claims and communicating our claim decisions

You or your **provider** are required to send us a claim in writing. You can request a claim form from us. And we will review that claim for payment to the **provider**.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

### Urgent care claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

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

### Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

### Post-service claim

A post service claim is a claim that involves health care services you have already received.

### Concurrent care claim extension

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

### Concurrent care claim reduction or termination

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

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

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your **physician** about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the **hospital**.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (us)	72 hours	15 days	30 days	24 hours for urgent request*  15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (us)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

\*We have to receive the request at least 24 hours before the previously approved health care services end.

### Adverse benefit determinations

We pay many claims at the full rate **negotiated charge** with a **network provider** and the **recognized amount** with an **out-of-network provider**, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

### The difference between a complaint and an appeal

#### A Complaint

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

#### An Appeal

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

#### Appeals of adverse benefit determinations

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

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

- Your name
- The employer’s name

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

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

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

### Urgent care or pre-service claim appeals

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

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

### Timeframes for deciding appeals

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

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

### Exhaustion of appeals process

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

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

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

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

## External review

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

You have a right to external review only if:

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

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

You must submit the Request for External Review Form:

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

**Aetna** will:

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

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

When an appeal is not eligible for ERO or when the appeal is upheld at the ERO level, Aetna will inform the member of their right to appeal to the plan sponsor for voluntary level of review.

### How long will it take to get an ERO decision?

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

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

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

#### **For initial adverse determinations**

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

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

### **For final adverse determinations**

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

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

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

### **Recordkeeping**

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

### **Fees and expenses**

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



## Coordination of benefits

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

### Key terms

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

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

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

### Here’s how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist.
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the benefits to the lesser of:
  - What the plan would have paid if it had been primary
  - What the plan would have paid less the primary plans payment.

### Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

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

<b>If you are covered as a:</b>	<b>Primary plan</b>	<b>Secondary plan</b>
Non-dependent or Dependent	The plan covering you as an employee or retired employee.	The plan covering you as a dependent.
Exception to the rule above when you are eligible for Medicare	If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us: <ul style="list-style-type: none"><li>• <b>Online:</b> Log on to your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a>. Select Find a Form, then select Your Other Health Plans.</li><li>• <b>By phone:</b> Call the toll-free Member Services number on your ID card.</li></ul>	

<b>COB rules for dependent children</b>		
Child of: <ul style="list-style-type: none"> <li>• Parents who are married or living together</li> </ul>	The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the <b>calendar year</b> .  *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)*.  *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together</li> <li>• With court-order</li> </ul>	The plan of the parent whom the court said is responsible for health coverage. But if that parent has no coverage then the other spouse’s plan.	The plan of the other parent.  But if that parent has no coverage, then his/her spouse’s plan is primary.
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</li> </ul>	Primary and secondary coverage is based on the birthday rule.	
Child of: <ul style="list-style-type: none"> <li>• Parents separated or divorced or not living together and there is no court-order</li> </ul>	The order of benefit payments is: <ul style="list-style-type: none"> <li>• The plan of the custodial parent pays first</li> <li>• The plan of the spouse of the custodial parent (if any) pays second</li> <li>• The plan of the noncustodial parents pays next</li> <li>• The plan of the spouse of the noncustodial parent (if any) pays last</li> </ul>	
Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee).	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee).
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage.	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree.
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally.	

## How are benefits paid?

Primary plan	The primary plan pays your claims as if there is no other health plan involved.
Secondary plan	<p>The secondary plan calculates payment as if the primary plan did not exist and we compare that benefit to the primary plan's benefit.</p> <p>If the primary plan's benefit is equal to or more than our benefit, we don't pay a benefit.</p> <p>If the primary plan's benefit is less than our benefit, we pay the difference between the primary plan's benefit and our benefit.</p>
Benefit reserve each family member has a separate benefit reserve for each <b>calendar year</b>	<p>The benefit reserve:</p> <ul style="list-style-type: none"><li>• Is made up of the amount that the secondary plan saved due to COB</li><li>• Is used to cover any unpaid allowable expenses</li><li>• Balance is erased at the end of each year</li></ul>

## How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

### Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	Primary plan	Secondary plan
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
<b>If you have Medicare because of:</b>		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months.	Medicare
	Medicare will pay first after this 30 month period.	Your plan
A disability other than ESRD and the employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary <b>plan</b> and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

### How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate the amount we would pay if there were no Medicare coverage. If the Medicare payment is equal to or more than what we would pay, we make no payment. If Medicare paid less than what we would pay, we pay the difference between our payment and the Medicare payment.

### Other health coverage updates – contact information

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

- **Online:** Log on to your Aetna member website at [www.aetna.com](http://www.aetna.com). Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free Member Services number on your ID card.

### Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

**Right to pay another carrier**

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

**Right of recovery**

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.

## When coverage ends

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

### When will your coverage end?

Your coverage under this plan will end if:

- This plan is discontinued.
- You voluntarily stop your coverage.
- The group contract ends.
- You are no longer eligible for coverage, including when you move out of the service area.
- Your employment ends.
- You do not make any required contributions.
- We end your coverage.
- You become covered under another medical plan offered by your employer.

### When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of <b>illness, injury</b>, sabbatical or other authorized leave as agreed to by your employer and us.</p>	<p>If required contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>• Your coverage may continue, until stopped by your employer.</li> </ul>
<p>Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer.</p>	<p>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>• Your coverage will stop on the date that your employment ends.</li> </ul>
<p>Your employment ends because:</p> <ul style="list-style-type: none"> <li>• Your job has been eliminated</li> <li>• You have been placed on severance, or</li> <li>• This plan allows former employees to continue their coverage.</li> </ul>	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid medical leave of absence</p>	<p>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>• Your coverage may continue until stopped by your employer.</li> </ul>

Your employment ends because of a leave of absence that is not a medical leave of absence	<p>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.</li> </ul>
Your employment ends because of a military leave of absence.	<p>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</p> <ul style="list-style-type: none"> <li>Your coverage may continue until stopped by your employer but not beyond 24 months from the start of the absence.</li> </ul>

It is your employer’s responsibility to let us know when your employment ends. The limits above may be extended only if your employer agrees in writing to extend them.

### **When will coverage end for any dependents?**

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage.
- You do not make the required contribution toward the cost of dependents’ coverage.
- Your coverage ends for any of the reasons listed above other than:
  - Exhaustion of your overall maximum benefit
  - If you enroll under a group Medicare plans that we offer. However, dependent’s coverage will end if your coverage ends under the Medicare plan
- Your dependent has exhausted his or her maximum benefit under your medical plan.

In addition, coverage for your domestic partner or civil union partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners or civil unions.
- The date the domestic partnership or civil union ends. For domestic partnerships, you should provide the employer a completed and signed Declaration of Termination of Domestic Partnership.

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

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

### **Why would we end you and your dependents coverage?**

We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *Additional information - Intentional deception* section for more information on rescissions.

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

## **When will we send you a notice of your coverage ending?**

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in “Why we would end your coverage”).

Your coverage will end on either the date you stop active work, or the day before the first contribution due date that occurs after you stop active work.

Coverage will end for you and any dependents on the earlier of the date the group contract terminates or at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.



## Special coverage options after your plan coverage ends

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

### Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

#### What are your COBRA rights?

COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued.

<b>Qualifying event causing loss of coverage</b>	<b>Covered persons eligible for continued coverage</b>	<b>Length of continued coverage (starts from the day you lose current coverage)</b>
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependent under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy	You and your dependents	18 months

## When do I receive COBRA information?

The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

<b>Employer/Group health plan notification requirements</b>		
<b>Notice</b>	<b>Requirement</b>	<b>Deadline</b>
<b>General notice – employer or Aetna</b>	Notify you and your dependents of COBRA rights.	Within 90 days after active employee coverage begins
Notice of qualifying event – employer	<ul style="list-style-type: none"> <li>• Your active employment ends for reasons other than gross misconduct</li> <li>• Your working hours are reduced</li> <li>• You become entitled to benefits under Medicare</li> <li>• You die</li> <li>• You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy</li> </ul>	Within 30 days of the qualifying event or the loss of coverage, whichever occurs later
Election notice – employer or <b>Aetna</b>	Notify you and your dependents of COBRA rights when there is a qualifying event	Within 14 days after notice of the qualifying event
Notice of unavailability of COBRA – employer or <b>Aetna</b>	Notify you and your dependents if you are not entitled to COBRA coverage.	Within 14 days after notice of the qualifying event
Termination notice – employer or <b>Aetna</b>	Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period	As soon as practical following the decision that continuation coverage will end

<b>You/your dependents notification requirements</b>		
Notice of qualifying event – qualified beneficiary	Notify the employer if: <ul style="list-style-type: none"> <li>You divorce or legally separate and are no longer responsible for dependent coverage</li> <li>Your covered dependent children no longer qualify as a dependent under the plan</li> </ul>	Within 60 days of the qualifying event or the loss of coverage, whichever occurs later
Disability notice	Notify the employer if: <ul style="list-style-type: none"> <li>The Social Security Administration determines that you or a covered dependent qualify for disability status</li> </ul>	Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends
Notice of qualified beneficiary's status change to non-disabled	Notify the employer if: <ul style="list-style-type: none"> <li>The Social Security Administration decides that the beneficiary is no longer disabled</li> </ul>	Within 30 days of the Social Security Administration's decision
Enrollment in COBRA	Notify the employer if: <ul style="list-style-type: none"> <li>You are electing COBRA</li> </ul>	60 days from the qualifying event. You will lose your right to elect, if you do not: <ul style="list-style-type: none"> <li>Respond within the 60 days</li> <li>And send back your application</li> </ul>

### **How can you extend the length of your COBRA coverage?**

The chart below shows qualifying events after the start of COBRA (second qualifying events):

<b>Qualifying event</b>	<b>Person affected (qualifying beneficiary)</b>	<b>Total length of continued coverage</b>
Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)	You and your dependents	29 months (18 months plus an additional 11 months)
<ul style="list-style-type: none"> <li>You die</li> <li>You divorce or legally separate and are no longer responsible for dependent coverage</li> <li>You become entitled to benefits under Medicare</li> <li>Your covered dependent children no longer qualify as dependent under the plan</li> </ul>	You and your dependents	Up to 36 months

### **How do you enroll in COBRA?**

You enroll by sending in an application and paying the **premium**. The employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the **premium**. If this is completed on time, you have enrolled in COBRA.

### **When is your first premium payment due?**

Your first **premium** payment must be made within 45 days after the date of the COBRA election.

### **How much will COBRA coverage cost?**

For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

### **Can you add a dependent to your COBRA coverage?**

You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:

- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required **premiums**.

### **When does COBRA coverage end?**

COBRA coverage ends if:

- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

### **Continuation of coverage for other reasons**

To request an extension of coverage, just call the toll-free Member Services number on your ID card.

### **How can you extend coverage for hearing services and supplies when coverage ends?**

If your coverage ends while you are not totally disabled, your plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

### **How can you extend coverage for your disabled child beyond the plan age limits?**

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

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

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

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

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

### **How can you extend coverage for a child in college on medical leave?**

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins, or
- The date coverage would otherwise end.

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**,
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating doctor as **medically necessary** due to a serious **illness or injury**.

The doctor treating your child will be asked to keep us informed of any changes.

## General provisions – other things you should know

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### Administrative information

#### Who's responsible to you

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

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

### Coverage and services

#### Your coverage can change

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

#### If a service cannot be provided to you

Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can't, we may refund you or the employer any unearned **premium**.

### Legal action

You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the *When you disagree -claim decisions and appeal procedures* section. You cannot take any action until 60 days after we receive written submission of claim.

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

### Physical examinations and evaluations

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

### Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

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

## Honest mistakes and intentional deception

### Honest mistakes

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

### Intentional deception

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

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

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

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an **Aetna** appeal.
- You have the right to a third party review conducted by an independent external review organization.

## Financial information

### Assignment of benefits

When you see a **network provider** they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an **out-of-network provider** or facility under this plan. This may include:

- The benefits due
- The right to receive payments or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this plan.

### Financial sanctions exclusions

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

### Recovery of overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator - Aetna. Under this process, Aetna reduces future payments

to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

## **SUBROGATION AND RIGHT OF RECOVERY**

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

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

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

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

### **Subrogation**

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

### **Reimbursement**

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

### **Constructive Trust**

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



insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

### **Lien Rights**

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

### **Assignment**

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

### **First-Priority Claim**

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

### **Applicability to All Settlements and Judgments**

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

### **Cooperation**

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

denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

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

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

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

### **Interpretation**

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

### **Jurisdiction**

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

## Effect of benefits under other plans

### Effect of a Health Maintenance Organization plan (an HMO Plan) on coverage

If you are eligible and have chosen medical coverage under an HMO plan offered by the employer, you will be excluded from medical coverage (except vision care, if any,) on the date of your coverage under the HMO plan.

<b>If you and your covered dependents:</b>	<b>Change of coverage:</b>	<b>Coverage takes effect:</b>
Live in an HMO plan enrollment area	During an open enrollment period	Group contract anniversary date after the open enrollment period
Live in an HMO plan enrollment area	Not during an open enrollment period	Only if and when we give our written consent
Move from an HMO plan enrollment area or the HMO discontinues	Within 31 days	On the date you elect such coverage
Move from an HMO plan enrollment area or the HMO discontinues	After 31 days	Only if and when we give our written consent

No benefits will be paid for any charges for services rendered or supplies received under an HMO plan.

### Continuation of coverage for other reasons

Health coverage under this plan will continue uninterrupted as to your dependent college student who takes a medically necessary leave of absence from school. See the *Special coverage options after your plan coverage ends – How can you extend coverage for a child in college on medical leave?* section.

### Sutter Health and Affiliates Services

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

## Glossary

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### **Aetna**

**Aetna Life Insurance Company**, an affiliate, or a third party vendor under contract with **Aetna**.

### **Ambulance**

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

### **Behavioral health provider**

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for **mental disorders** and **substance abuse** under the laws of the jurisdiction where the individual practices.

### **Body mass index**

This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

### **Brand-name prescription drug**

A U.S. Food and Drug Administration (FDA) approved **prescription drug** marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

### **Copay/Copayments**

The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

### **Cosmetic**

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

### **Covered benefits**

**Eligible health services** that meet the requirements for coverage under the terms of this plan, including:

1. They are **medically necessary**.
2. You received **precertification** if required.

### **Custodial care**

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be **custodial care** even if it prescribed by a **physician** or given by trained medical personnel.

### **Deductible**

The amount you pay for **eligible health services** per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

### **Detoxification**

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

## Directory

The list of **network providers** for your plan. The most up-to-date directory for your plan appears at [www.aetna.com](http://www.aetna.com) under the provider search label. When searching provider search, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans.

## Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

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

## Effective date of coverage

The date your and your dependent's coverage begins under this booklet as noted in your employer's records.

## Eligible health services

The health care services and supplies listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits.

## Emergency admission

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

## Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness**, or **injury** is of a severe nature. And that if you don't get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

## Emergency services

Treatment given in a **hospital's** emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.

## **Experimental or investigational**

A drug, device, procedure, or treatment that is found to be **experimental or investigational** because:

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

## **Generic prescription drug**

A **prescription drug** with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

## **Health professional**

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, **physicians**, nurses, and physical therapists.

## **Home health care agency**

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

## **Home health care plan**

A plan of services prescribed by a **physician** or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a **hospital** or if you are homebound.

## **Hospice care**

Care designed to give supportive care to people in the final phase of a **terminal illness** and focus on comfort and quality of life, rather than cure.

## **Hospice care agency**

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

## **Hospice care program**

A program prescribed by a **physician** or other **health professional** to provide **hospice care** and supportive care to their families.

## **Hospice facility**

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide **hospice care**.

## Hospital

An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

**Hospital** does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- **Psychiatric hospital**
- **Residential treatment facility for substance abuse**
- **Residential treatment facility for mental disorders**
- Extended care facility
- Intermediate care facility
- **Skilled nursing facility**

## Illness

Poor health resulting from disease of the body or mind.

## Infertile/infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

## Injury

Physical damage done to a person or part of their body.

## Institutes of Excellence™ (IOE) facility

A facility designated by **Aetna** in the **provider directory** as Institutes of Excellence **network provider** for specific services or procedures.

## Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of **medically necessary** services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a **mental disorder** or **substance abuse** issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

## Jaw joint disorder

This is:

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

## L.P.N.

A licensed practical nurse or a licensed vocational nurse.

## Mail order pharmacy

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

## Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of **copayments** and payment percentage including any **deductible**, to be paid by you or any covered dependents per Calendar Year for **eligible health services**.

## Medically necessary/Medical necessity

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

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

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

## Mental disorder

A **mental disorder** as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

## Morbid obesity/morbidly obese

This means the **body mass index** is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes



## Negotiated charge

*For health coverage, this is either:*

- The amount a **network provider** has agreed to accept
- The amount we agree to pay directly to a **network provider** or third party vendor (including any administrative fee in the amount paid)

for providing services, **prescription drugs** or supplies to plan members. This does not include **prescription drug** services from a **network pharmacy**.

## Network provider

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

## Out-of-network pharmacy

A **pharmacy** that is not a **network pharmacy** or a National Advantage Program (NAP) **provider** and does not appear in the **directory** for your plan.

## Out-of-network provider

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

## Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be **medically necessary** and provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental disorder** or **substance abuse** issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

## Payment Percentage

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

## Pharmacy

An establishment where **prescription** drugs are legally dispensed. This includes a **retail pharmacy**, **mail order pharmacy** and **specialty pharmacy**.

## Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

## Precertification, precertify

A requirement that you or your **physician** contact **Aetna** before you receive coverage for certain services. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

## Prescriber

Any **provider** acting within the scope of his or her license, who has the legal authority to write an order for outpatient **prescription drugs**.

## Prescription

A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **network pharmacy**.

## Prescription drug

An FDA approved drug or biological which can only be dispensed by **prescription**.

## Primary care physician (PCP)

A **physician** who:

- The **directory** lists as a **PCP**
- Is selected by a person from the list of **PCPs** in the **directory**
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care **physician**, an internist, a pediatrician
- Is shown on **Aetna's** records as your **PCP**

## Provider(s)

A **physician**, other **health professional**, **hospital**, **skilled nursing facility**, **home health care agency** or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

## Psychiatric hospital

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

## Psychiatrist

A **psychiatrist** generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

## Recognized charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

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

- If your service was received from a NAP **provider**, a pre-negotiated charge will be paid. NAP **providers** are **out-of-network providers** that have contracts with **Aetna**, directly or through third-party vendors, that include a pre-**negotiated charge** for services. NAP **providers** are not **network providers**.
- If your service was not received from a NAP **provider**, a claim specific rate or discount may be negotiated by **Aetna** or a third-party vendor.

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

Service or Supply	Out-of-Network Plan Rate
Professional services	An amount determined by <b>Aetna</b> , or its third-party vendors, based on data resources selected by <b>Aetna</b> , reflecting typical competitive charges and/or payments for a service, adjusted for the <b>geographic area</b> in which the service was provided.
Inpatient and outpatient charges of <b>hospitals</b>	Facility Charge Review
Inpatient and outpatient charges of facilities other than <b>hospitals</b>	

**Important note:** If the **provider** bills less than the amount calculated using the **out-of-network plan rate** described above, the **recognized charge** is what the **provider** bills.

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

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

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
- Not available from a **network provider**
- **Emergency services**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.

#### Special terms used

- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility **provider's** estimated costs for the service and leave the facility **provider** with a reasonable profit. For **hospitals** and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the **recognized charge**. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the **recognized charge**.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the **provider**

Our reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

#### **Get the most value out of your benefits**

We have online tools to help you decide where to get care. Use the "Estimate the Cost of Care" tool on Aetna's member website. **Aetna's** secure member website at [www.aetna.com](http://www.aetna.com) may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna's member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

## **R.N.**

A registered nurse.

## **Residential treatment facility (mental disorders)**

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by **Aetna** or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

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

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a **psychiatrist** at least once per week.

- The medical director must be a **psychiatrist**.
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution).

### **Residential treatment facility (substance abuse)**

- An institution specifically licensed as a **residential treatment facility** by applicable state and federal laws to provide for **substance abuse** residential treatment programs. And is credentialed by **Aetna** or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for chemical dependence residential treatment programs:

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

In addition to the above requirements, for chemical dependence **detoxification** programs within a residential setting:

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

### **Room and board**

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

### **Semi-private room rate**

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

### **Skilled nursing facility**

A facility specifically licensed as a **skilled nursing facility** by applicable state and federal laws to provide skilled nursing care.

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

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

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

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

## Skilled nursing services

Services provided by an **R.N.** or **L.P.N.** within the scope of their license.

## Specialist

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

## Stay

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

## Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a **mental disorder** that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

## Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient **surgery** services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

## Surgery or surgical procedures

The diagnosis and treatment of **injury**, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

## Telemedicine

A consultation between you and a **provider** who is performing a clinical medical or behavioral health service.

Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls , except for behavioral health services
- Any other method required by state law

## Terminal illness

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

## Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

## Urgent condition

An **illness** or **injury** that requires prompt medical attention but is not an **emergency medical condition**.

## **Walk-in clinic**

A freestanding health care facility. Neither of the following should be considered a **walk-in clinic**:

- An emergency room
- The outpatient department of a **hospital**

# **Additional Information Provided by**

## **The McClatchy Company**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

**Name of Plan:**

The McClatchy Company Comprehensive Welfare Benefit and Cafeteria Plan

**Employer Identification Number:**

52-2080478

**Plan Number:**

005

**Type of Plan:**

Group Health Plan

**Type of Administration:**

Administrative Services Contract with:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:**

The McClatchy Company  
2100 Q Street  
Sacramento, CA 95816-6889

**Agent For Service of Legal Process:**

The McClatchy Company  
2100 Q Street  
Sacramento, CA 95816-6889

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**

December 31

**Source of Contributions:**

Employer and Employee

**Procedure for Amending the Plan:**

The Employer may amend the Plan from time to time by a written instrument signed by the Board of Directors, or Management, if such authority has been delegated by the Board of Directors.



## **ERISA Rights**

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

### **Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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

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

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

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

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

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, [http://www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

# **IMPORTANT HEALTH CARE REFORM NOTICES**

## **CHOICE OF PROVIDER**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## Choice POS II Medical Plan

### Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

**Prepared exclusively for:**

<b>Employer:</b>	The McClatchy Company
<b>Contract number:</b>	620229
	Schedule of Benefits 2A
Plan effective date:	January 1, 2019
Plan issue date:	January 1, 2019

**These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.**

## Schedule of benefits

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This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

### How to read your schedule of benefits

- When we say:
  - “In-network coverage”, we mean you get care from a **network provider**.
  - “Out-of-network coverage”, we mean you can get care from **providers** who are not **network providers**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**
  - Maximums

#### Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna member website at [www.aetna.com](http://www.aetna.com) or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums	
	In-network coverage*	Out-of-network coverage*
<b>Deductible</b>		
You have to meet your Calendar Year <b>deductible</b> before this plan pays for benefits.		
IndividualEmployee Only	\$2,000 per Calendar Year	\$3,300 per Calendar Year
Employee + Spouse or Child(ren)	\$4,000 per Calendar Year	\$4,950 per Calendar Year
Employee +Family	\$6,000 per Calendar Year	\$6,600 per Calendar Year
<b>Deductible waiver</b>		
The Calendar Year in-network <b>deductible</b> is waived for all of the following <b>eligible health services</b> :		
<ul style="list-style-type: none"> <li>• Preventive care and wellness</li> <li>• Family planning services - female contraceptives</li> </ul>		
<b>Maximum out-of-pocket limit</b>		
<b>Maximum out-of-pocket limit</b> per Calendar Year.		
IndividualEmployee Only	\$5,000 per Calendar Year	\$6,350 per Calendar Year
Employee + Spouse of Child(ren)	\$7,500 per Calendar Year	\$9,525 per Calendar Year
Employee + Family	\$10,000 per Calendar Year	\$12,700 per Calendar Year
<b>Precertification covered benefit reduction</b>		
This only applies to out-of-network coverage. The booklet contains a complete description of the <b>precertification</b> program. You will find details on <b>precertification</b> requirements in the <i>Medical necessity and precertification requirements</i> section.		
Failure to <b>precertify</b> your <b>eligible health services</b> when required will result in the following benefits reduction:		
<ul style="list-style-type: none"> <li>• A \$250 benefit reduction will be applied separately to each type of <b>eligible health services</b> or</li> <li>• The <b>eligible health services</b> will not be covered.</li> </ul>		
The additional percentage or dollar amount of the <b>recognized charge</b> which you may pay as a penalty for failure to obtain <b>precertification</b> is not a <b>covered benefit</b> , and will not be applied to the <b>deductible</b> amount or the <b>maximum out-of-pocket limit</b> , if any.		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits



Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Preventive care and wellness</b>		
<b>Routine physical exams</b>		
Performed at a <b>physician's, PCP</b> office	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per 24 months	1 visit	1 visit
Covered persons age 65 and over: Maximum visits per 12 months	1 visit	1 visit
<b>Preventive care immunizations</b>		
Performed in a facility or at a <b>physician's</b> office	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Well woman preventive visits routine gynecological exams (including pap smears)</b>		
Performed at a <b>physician's, PCP,</b> obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit
<b>Preventive screening and counseling services</b>		
Office visits <ul style="list-style-type: none"> <li>• Obesity and/or healthy diet counseling</li> <li>• Misuse of alcohol and/or drugs</li> <li>• Use of tobacco products</li> <li>• Sexually transmitted infection counseling</li> <li>• Genetic risk counseling for breast and ovarian cancer</li> </ul>	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
<b>Obesity and/or healthy diet counseling maximums:</b>		
Maximum visits per 12 months  (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only <i>10</i> visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these, only <i>10</i> visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
<b>Misuse of alcohol and/or drugs maximums:</b>		
Maximum visits per 12 months	5 visits*	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Use of tobacco products maximums:</b>		
Maximum visits per 12 months	8 visits*	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.		
<b>Sexually transmitted infection counseling maximums:</b>		
Maximum visits per 12 months	2 visits*	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.		
<b>Genetic risk counseling for breast and ovarian cancer maximums:</b>		
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations
<b>Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)</b>		
Routine cancer screenings	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul> For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	1 screening every 12 months*
<b>*Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Prenatal care</b>		
<b>Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>		
Preventive care services only	100% per visit  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
<b>Important note:</b> You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
<b>Comprehensive lactation support and counseling services</b>		
Lactation counseling services – facility or office visits	100% per visit  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*Not applicable
<b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under <b>Physician</b> services office visits.		
<b>Breast feeding durable medical equipment</b>		
Breast pump supplies and accessories	100% per item  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per item
<b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.		
<b>Family planning services – female contraceptives</b>		
<b>Counseling services</b>		
Female contraceptive counseling services office visit	100% per visit  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per visit
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*Not applicable
<b>*Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under <b>Physician</b> services office visits.		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Devices</b>		
Female contraceptive device provided, administered, or removed, by a <b>physician</b> during an office visit	100% per item  No <b>deductible</b> applies	60% (of the <b>recognized charge</b> ) per item
<b>Female voluntary sterilization</b>		
Inpatient	100% per admission  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per admission  No <b>deductible</b> applies
Outpatient	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Physicians and other health professionals</b>		
<b>Physicians and specialists</b> office visits (non-surgical)		
<b>Physician services</b>		
Office hours visits (non-surgical) non preventive care	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Immunizations that are not considered preventive care</b>		
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Specialist</b>		
<b>Specialist office visits</b>		
Office hours visits (non-surgical)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Physician surgical services</b>		
<b>Physicians and specialists</b> office visits		
Performed at a <b>physician's, PCP</b> office	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Performed at a <b>specialist's</b> office	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Alternatives to physician office visits</b>		
<b>Walk-in clinic visits</b>		
<b>Preventive Care Services</b>		
Immunizations	100% per visit  No <b>deductible</b> applies	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.  For details, contact your <b>physician</b> or Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

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<b>All non preventive care services for which cost sharing is not shown above</b>		
All other services	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Travel immunizations</b>	80% (of the <b>negotiated charge</b> ) per visit	80% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Hospital and other facility care</b>		
<b>Hospital care</b>		
Inpatient hospital	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Alternatives to hospital stays</b>		
<b>Outpatient surgery and physician surgical services</b>		
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Home health care</b>		
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	120	120
<b>Hospice care</b>		
Inpatient facility	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
Maximum days per lifetime	Unlimited	Unlimited
<b>Hospice care</b>		
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Outpatient private duty nursing</b>		
Outpatient private duty nursing	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits/shifts per Calendar Year	70 shifts Up to eight hours equal one shift.	70 shifts Up to eight hours equal one shift.
<b>Skilled nursing facility</b>		
Inpatient facility	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
Maximum days per Calendar Year	100	100

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits



Eligible health services	In-network coverage*	Out-of-network coverage*
<b>Emergency services and urgent care</b>		
<b>Emergency services</b>		
Hospital emergency room	80% (of the <b>negotiated charge</b> ) per visit	Paid the same as in-network coverage
Non-emergency care in a <b>hospital</b> emergency room	Not covered	Not covered
<p><b>Important Note:</b>  As <b>out-of-network providers</b> do not have a contract with us the <b>provider</b> may not accept payment of your cost share, (<b>deductible, copayment, and coinsurance</b>), as payment in full. You may receive a bill for the difference between the amount billed by the <b>provider</b> and the amount paid by this plan. If the <b>provider</b> bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the <b>provider</b> over that amount. Make sure the member's ID number is on the bill.</p>		
<b>Urgent care</b>		
Urgent medical care (at a non- <b>hospital</b> free standing facility)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Specific conditions</b>		
<b>Birthing center</b>		
Inpatient	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Diabetic equipment, supplies and education</b>		
Diabetic equipment, supplies and education	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Family planning services - other</b>		
<b>Voluntary sterilization for males</b>		
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Abortion</b>		
Outpatient	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Jaw joint disorder treatment</b>		
Jaw joint disorder treatment	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Maternity and related newborn care</b>		
Inpatient	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Delivery services and postpartum care services</b>		
Performed in a facility or at a <b>physician's</b> office	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Mental health treatment - inpatient</b>		
Inpatient mental health treatment	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
Inpatient <b>residential treatment facility</b>		

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Coverage is provided under the same terms, conditions as any other <b>illness</b> .		
<b>Mental health treatment - outpatient</b>		
Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> consultation  Coverage is provided under the same terms, conditions as any other <b>illness</b> .	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Outpatient mental health treatment office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavioral therapy consultation	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home)  <b>Partial hospitalization treatment</b> (at least 4 hours, but less than 24 hours per day of clinical treatment)  <b>Intensive outpatient program</b> (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Substance related disorders treatment - inpatient</b>		
<p>Inpatient <b>substance abuse detoxification</b> during a <b>hospital</b> confinement</p> <p>Inpatient <b>substance abuse</b> rehabilitation during a <b>hospital</b> confinement</p> <p>Inpatient <b>residential treatment facility</b> during a <b>hospital</b> confinement</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per admission	60% (of the <b>recognized charge</b> ) per admission
<b>Substance related disorders treatment - outpatient: detoxification and rehabilitation</b>		
<p>Outpatient <b>substance abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> (includes <b>telemedicine</b> consultation)</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<p>Outpatient <b>substance abuse</b> office visits to a <b>physician</b> or <b>behavioral health provider</b> includes <b>telemedicine</b> cognitive behavioral therapy consultations</p> <p>Coverage is provided under the same terms, conditions as any other <b>illness</b>.</p>	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Other outpatient substance abuse services (includes skilled <b>behavioral health services</b> in the home)  <b>Partial hospitalization treatment</b> (at least 4 hours, but less than 24 hours per day of clinical treatment)  <b>Intensive Outpatient Program</b> (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Obesity surgery</b>		
Inpatient <b>hospital</b> (includes surgical procedure and acute <b>hospital</b> services)	50% (of the <b>negotiated charge</b> ) per admission	Not covered
<b>Outpatient obesity surgery</b>		
	50% (of the <b>negotiated charge</b> ) per visit	Not covered
Maximum per lifetime*	\$5,000	Not covered
*As used for this benefit, "lifetime" is defined to include covered benefits paid under this plan or another plan underwritten and/or administered by <b>Aetna</b> or any <b>Aetna</b> affiliate, with the same customer.		
<b>Oral and maxillofacial treatment (mouth, jaws and teeth)</b>		
Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Reconstructive breast surgery</b>		
Reconstructive breast <b>surgery</b>	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Reconstructive surgery and supplies</b>		
Reconstructive <b>surgery</b>	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>Network (IOE facility)</b>	<b>Network (Non-IOE facility)</b>	<b>Out-of-network coverage*</b>
<b>Transplant services facility and non-facility</b>			
Inpatient <b>hospital</b> transplant services	80% (of the <b>negotiated charge</b> ) per transplant	60% (of the <b>negotiated charge</b> ) per transplant	60% (of the <b>recognized charge</b> ) per transplant
<b>Physician</b> services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Eligible health services</b>	<b>In-network coverage*</b>		<b>Out-of-network coverage*</b>
<b>Treatment of infertility</b>			
<b>Basic infertility</b>			
Basic <b>infertility</b>	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Specific therapies and tests</b>		
<b>Outpatient diagnostic testing</b>		
<b>Diagnostic complex imaging services</b>		
	80% (of the <b>negotiated</b> charge) per visit	60% (of the <b>recognized</b> charge) per visit
<b>Diagnostic lab work</b>		
	80% (of the <b>negotiated</b> charge) per visit.	60% (of the <b>recognized</b> charge) per visit.
<b>Diagnostic radiological services</b>		
	80% of the <b>negotiated charge</b> per visit.	60% of the <b>recognized charge</b> per visit.
<b>Chemotherapy</b>		
	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Outpatient infusion therapy</b>		
	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Outpatient radiation therapy</b>		
Radiation therapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Short-term cardiac and pulmonary rehabilitation services</b>		
<b>Cardiac rehabilitation</b>		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Pulmonary rehabilitation</b>		
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Short-term rehabilitation services</b>		
<b>Outpatient Physical, Occupational and Speech Therapies</b>		
	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
<b>Neurodevelopmental therapy</b> For a covered dependent child to age 6.	80% (of the <b>negotiated charge</b> ) per visit thereafter	60% (of the <b>recognized charge</b> ) per visit

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits



<b>Eligible health services</b>	<b>In-network coverage*</b>	<b>Out-of-network coverage*</b>
<b>Other services</b>		
<b>Acupuncture</b>		
Acupuncture	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	12	12
<b>Ambulance service</b>		
Ground, air or water ambulance	80% (of the <b>negotiated charge</b> ) per trip	80% (of the <b>recognized charge</b> ) per trip
<b>Clinical trial therapies (experimental or investigational)</b>		
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Clinical trials (routine patient costs)</b>		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Durable medical equipment (DME)</b>		
DME	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
<b>Hearing aids and exams</b>		
Hearing aid exams	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Hearing aids	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
Hearing Aid maximum		
Adults age 19 and over per 36 month period	\$1,000	\$1,000
Maximum Children through age 18 per 24 month period	\$1,000	\$1,000

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Non-preventive hearing exams</b>		
For adults and children	100% (of the <b>negotiated charge</b> ) per visit  No <b>deductible</b> applies.	100% (of the <b>recognized charge</b> ) per visit  No <b>deductible</b> applies.
Maximum	One exam in any 24 consecutive month period.	
<b>Prosthetic devices</b>		
Prosthetic devices	80% (of the <b>negotiated charge</b> ) per item	60% (of the <b>recognized charge</b> ) per item
<b>Spinal manipulation</b>		
Spinal manipulation	80% (of the <b>negotiated charge</b> ) per visit	60% (of the <b>recognized charge</b> ) per visit
Maximum visits per Calendar Year	20	20

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Eligible health services*</b>	
<b>Family planning services - female contraceptives</b>	
Female contraceptives that are <b>generic prescription drugs</b> :  <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Female contraceptives that are <b>brand-name prescription drugs</b> :  <ul style="list-style-type: none"> <li>• Oral drugs</li> <li>• Injectable drugs</li> <li>• Vaginal rings</li> <li>• Transdermal contraceptive patches</li> </ul>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Female contraceptive generic devices and brand-name devices	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
<b>Preventive care drugs and supplements</b>	
Preventive care drugs and supplements filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Risk reducing breast cancer prescription drugs</b>	
Risk reducing breast cancer <b>prescription drugs</b> filled at a <b>pharmacy</b>	100% per <b>prescription</b> or refill  No <b>deductible</b> applies
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.
<b>Tobacco cessation prescription and over-the-counter drugs</b>	
Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b> for each 90 day supply	\$0 per <b>prescription</b> or refill  No <b>deductible</b> applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.  Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation <b>prescription drugs</b> and OTC drugs, contact Member Services by logging onto your Aetna member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on your ID card.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

## General coverage provisions

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This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

<b>Deductible provisions</b>
<b>Eligible health services</b> applied to the out-of-network <b>deductibles</b> will not be applied to satisfy the in-network <b>deductibles</b> . <b>Eligible health services</b> applied to the in-network <b>deductibles</b> will not be applied to satisfy the out-of-network <b>deductibles</b> .
The <b>deductible</b> may not apply to certain <b>eligible health services</b> . You must pay any applicable <b>copayments/payment percentage</b> for <b>eligible health services</b> to which the <b>deductible</b> does not apply.
For purposes of the Calendar Year <b>deductible</b> provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family <b>deductible</b> can be met by one family member, or a combination of family members. For purposes of the Calendar Year <b>deductible</b> provision below: <ul style="list-style-type: none"><li>• The individual <b>deductible</b> applies to a person who is enrolled for self only coverage with no dependent coverage</li><li>• The family <b>deductible</b> applies to a person who is enrolled with one or more dependents. The family <b>deductible</b> can be met by one family member, or a combination of family members.</li></ul>
<b>Individual</b> This is the amount you owe for in-network and out-of-network <b>eligible health services</b> each Calendar Year before the plan begins to pay for <b>eligible health services</b> . After the amount you pay for <b>eligible health services</b> reaches this individual Calendar Year <b>deductible</b> , this plan will begin to pay for <b>eligible health services</b> for the rest of the Calendar Year.
<b>Family</b> This is the amount you and your covered dependents owe for in-network and out-of-network <b>eligible health services</b> each Calendar Year before the plan begins to pay for <b>eligible health services</b> . After the amount you and your covered dependents pay for <b>eligible health services</b> reach this family Calendar Year <b>deductible</b> , this plan will begin to pay for <b>eligible health services</b> that you and your covered dependents incur for the rest of the Calendar Year.
<b>Copayments</b>
<b>Copayment</b> As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive <b>eligible health services</b> from a <b>network provider</b> .

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Payment percentage</b>
The specific percentage the plan pays for a health care service listed in the schedule of benefits.
<b>Maximum out-of-pocket limits provisions</b>
<b>Eligible health services</b> applied to the <b>out-of-network maximum out-of-pocket limit</b> will not be applied to satisfy the in-network <b>maximum out-of-pocket limit</b> and <b>eligible health services</b> applied to the in-network <b>maximum out-of-pocket limit</b> will not be applied to satisfy the out-of-network <b>maximum out-of-pocket limit</b> .
The <b>maximum out-of-pocket limit</b> is the maximum amount you are responsible to pay for <b>copayments/payment percentage</b> and <b>deductibles</b> for <b>eligible health services</b> during the Calendar Year. This plan has an individual and family <b>maximum out-of-pocket limit</b> . As to the individual <b>maximum out-of-pocket limit</b> each of you must meet your <b>maximum out-of-pocket limit</b> separately.
<b>Individual</b> Once the amount of the <b>copayments/payment percentage</b> and <b>deductibles</b> you and your covered dependents have paid for <b>eligible health services</b> during the Calendar Year meets the individual <b>maximum out-of-pocket limit</b> , this plan will pay 100% of the <b>negotiated charge</b> or <b>recognized charge</b> for <b>covered benefits</b> that apply toward the limit for the rest of the Calendar Year for that person.
<b>Family</b> Once the amount of the <b>copayments/payment percentage</b> and <b>deductibles</b> you and your covered dependents have paid for <b>eligible health services</b> during the Calendar Year meets this family <b>maximum out-of-pocket limit</b> , this plan will pay 100% of the <b>negotiated charge</b> or <b>recognized charge</b> for such <b>covered benefits</b> that apply toward the limit for the remainder of the Calendar Year for all covered family members.
To satisfy this family <b>maximum out-of-pocket limit</b> for the rest of the Calendar Year, the following must happen: <ul style="list-style-type: none"> <li>• The family <b>maximum out-of-pocket limit</b> is a cumulative <b>maximum out-of-pocket limit</b> for all family members. The family <b>maximum out-of-pocket limit</b> can be met by a combination of family members with no single individual within the family contributing more than the individual <b>maximum out-of-pocket limit</b> amount in a Calendar Year.</li> </ul>
The <b>maximum out-of-pocket limit</b> may not apply to certain <b>eligible health services</b> . If the <b>maximum out-of-pocket limit</b> does not apply to a covered benefit, your <b>copayment/payment percentage</b> for that covered benefit will not count toward satisfying the <b>maximum out-of-pocket limit</b> amount.
Certain costs that you incur do not apply toward the <b>maximum out-of-pocket limit</b> . These include: <ul style="list-style-type: none"> <li>• All costs for non-covered services</li> <li>• All costs for non-emergency use of the emergency room</li> <li>• As it applies to out-of-network coverage: Charges, expenses or costs in excess of the <b>recognized charge</b></li> </ul>

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

<b>Maximum provisions</b>
<b>Eligible health services</b> applied to the <b>out-of-network</b> maximum will be applied to satisfy the network maximum and <b>eligible health services</b> applied to the network maximum will be applied to satisfy the <b>out-of-network</b> maximum.
<b>Calculations; determination of recognized charge; determination of benefits provisions</b>
Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

\*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

## Pharmacy Coverage Appendix

Coinsurance			
Three Tier Coinsurance Structure*	Mail	Paper Claim*	Retail
Generic All (Tier 1)	20%	20%	20%
Preferred Brand (Tier 2)	20%	20%	20%
Non-Preferred Brand (Tier 3)	20%	20%	20%

\* Paper claim is a manual submitted claim

### Your Pharmacy Benefit

Important Notices:

\* Certain drugs must be filled at CVS Caremark’s specialty pharmacy network. Refer to the plan’s formulary list for impacted drugs.

\*\* A 31-90 day supply of maintenance drugs may be filled at select network pharmacies. For participating pharmacies, contact CVS Caremark.

Prior Authorization and step therapy for certain prescription drugs is required. If Prior Authorization is not obtained, the prescription drug will not be covered.

The prescription drug plan coinsurance is the percentage of prescription drug covered expenses that the member pays after any applicable deductibles have been met.

### ACA Preventive Services

The per prescription coinsurance/coinsurance will not apply to risk-reducing breast cancer generic prescription drugs when obtained at a network pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Coinsurance/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs.

The per prescription coinsurance/coinsurance will not apply to the first two 90-day treatment regimens for tobacco cessation prescription drugs and OTC drugs when obtained at a network pharmacy. This means that such prescription drugs and OTC drugs will be paid at 100%. Your prescription coinsurance/coinsurance will apply after those two regimens have been exhausted.

Contraceptives

The per prescription coinsurance/coinsurance will not apply to contraceptive methods that are:

- Generic prescription drugs; contraceptive devices; or
- FDA-approved female generic emergency contraceptives, when obtained at a network pharmacy.

This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The coinsurance/coinsurance continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - brand-name prescription drugs and devices and



- FDA-approved female brand-name emergency contraceptives, that have a generic equivalent, or generic alternative available within the same therapeutic drug class obtained at an out-of-network pharmacy or network pharmacy unless you are granted a medical exception.

## Coinsurance and Deductible Waiver

### Deductible Waiver Provision for Preventive Prescription Drug Expenses

No **deductible** will apply to preventive covered **prescription drug** expenses for those **prescription drugs** used to treat the prevention of conditions relating to:

- Hypertension;
- Heart disease;
- Diabetic complications;
- Asthmatic episodes;
- Conditions resulting from osteoporosis; Stroke;
- Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy.

The preventive **prescription drug** list is available from your employer in printed form. Member Services can answer any questions you have about this preventive **prescription drug** list.

# Your Pharmacy Benefit

## How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your CVS Caremark prescription drug plan. This Booklet explains: Definitions you need to know; How to access network pharmacies and procedures you need to follow;

- What prescription drug expenses are covered and what limits may apply;
- What prescription drug expenses are not covered by the plan;
- How you share the cost of your covered prescription drug expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

Unless otherwise indicated, “you” refers to you and your covered dependents. The prescription drug plan pays benefits only for prescription drug expenses described in this Booklet as covered expenses that are medically necessary.

This Booklet applies to coverage only and does not restrict your ability to receive prescription drugs that are not or might not be covered benefits under this prescription drug plan.

- Store this Booklet in a safe place for future reference.

## Notice

The plan does not cover all prescription drugs, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet.

- Covered expenses are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage.
- Prescription drugs will only be covered when obtained through a network pharmacy.
- Injectable prescription drug refills will only be covered when obtained through CVS Caremark's specialty pharmacy network.

## Getting Started: Common Terms

**Brand-Named Prescription Drug** is a prescription drug with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by CVS Caremark.

**Generic Prescription Drug** is a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by CVS Caremark.

**Network pharmacy** is a description of a retail, mail order or specialty pharmacy that has entered into a contractual agreement with CVS Caremark, an affiliate, or a third party vendor, for the provision of covered services to you and your covered dependents. The appropriate pharmacy type may also be substituted for the word pharmacy. (E.g. network retail pharmacy, network mail order pharmacy or specialty pharmacy network).

**Non-Preferred Drug (Non-Formulary)** is a brand-named prescription drug or generic prescription drug that does not appear on the preferred drug guide.

**Out-of-network pharmacy** is a description of a pharmacy that has not contracted with CVS Caremark, an affiliate, or a third party vendor and does not participate in the pharmacy network.

**Preferred Drug (Formulary)** is a brand-named prescription drug or generic prescription drug that appears on the preferred drug guide.

**Preferred Drug Guide** is a listing of prescription drugs established by CVS Caremark or an affiliate, which includes both brand-named prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by CVS Caremark. A copy of the preferred drug guide will be available upon your request or may be accessed on the CVS Caremark website at [www.caremark.com](http://www.caremark.com).

**Prescription Drug** is a drug, biological, or compounded prescription which, by State or Federal Law, may be dispensed only by prescription and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin. Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

**Self-injectable Drug(s)**. Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

## Accessing Pharmacies and Benefits

This plan provides access to covered benefits through a network of pharmacies, vendors or suppliers. CVS Caremark has contracted for these network pharmacies to provide prescription drugs and other supplies to you. Obtaining your benefits through network pharmacies has many advantages. Benefits and cost sharing may also vary by the type of network pharmacy where you obtain your prescription drug and whether or not you purchase a brand-name or generic drug. Network pharmacies include retail, mail order and specialty pharmacies.

The plan will only pay for outpatient prescription drugs that you obtain from a network pharmacy. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you. To better understand the choices that you have with your plan, please carefully review the following information.

## Accessing Network Pharmacies and Benefits

You may select a network pharmacy from the CVS Caremark Network Pharmacy Directory or by logging on the CVS Caremark's website at [www.caremark.com](http://www.caremark.com). You can search CVS Caremark's online directory, for names and locations of network pharmacies. If you cannot locate a network pharmacy in your area call Member Services.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any deductible, coinsurance or payment percentage directly to the network pharmacy.

You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

## **Emergency Prescriptions**

When you need a prescription filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your prescription at any network retail pharmacy. The network pharmacy will fill your prescription and only charge you your plan's cost sharing amount. Coverage for prescription drugs obtained from an out-of-network pharmacy is limited to those obtained in connection with emergency and out-of-area urgent care services.

### **Availability of Providers**

CVS Caremark cannot guarantee the availability or continued network participation of a particular pharmacy. Either CVS Caremark or any network pharmacy may terminate the provider contract.

### **Cost Sharing for Network Benefits.**

You share in the cost of your benefits. Cost Sharing amounts and provisions:

- You will be responsible for the coinsurance for each prescription or refill as specified in the.
- The coinsurance is payable directly to the network pharmacy at the time the prescription is dispensed.

## **Pharmacy Benefit**

### **What the Plan Covers**

The CVS Caremark pharmacy benefits plan covers charges for outpatient prescription drugs for the treatment of an illness or injury, subject to the Limitations section of this coverage and the Exclusions section of the Booklet.

Prescriptions must be written by a prescriber licensed to prescribe federal legend prescription drugs.

Your prescription drug benefit coverage is based on CVS Caremark's preferred drug guide. The preferred drug guide includes both brand-name prescription drugs and generic prescription drugs.

Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug guide.

Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage of prescription drugs may, in CVS Caremark's sole discretion, be subject to Prior Authorization, step therapy or other CVS Caremark requirements or limitations.

Prescription drugs covered by this plan are subject to drug utilization review by CVS Caremark and/or your provider and/or your network pharmacy.

Coverage for prescription drugs and supplies is limited to the supply limits as described below.

## **Retail Pharmacy Benefits**

In addition to your standard retail network options for immediate medication needs, you will also have the convenience of getting your long-term medications for up to a 90 day supply at either a specific network of retail pharmacies or through CVS Caremark's mail service.

## **Mail Order Pharmacy Benefits**

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

## **Network Benefits for Specialty Care Drugs**

**Specialty drugs** are covered at the network level of benefits only when dispensed through a CVS Health specialty pharmacy. Claims for specialty products will not be processed through the retail network, except for those specialty drugs that CVS Health's specialty pharmacies are unable to dispense.

The initial prescription for specialty drugs can be filled at a network retail pharmacy or at CVS Caremark's specialty pharmacy network.

You are required to obtain specialty drugs at CVS Caremark's specialty pharmacy network for all prescription drug refills after the first refill.

**Specialty Copay Card** – Some specialty medications may qualify for third-party compayment assistance programs that could lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

## **Other Covered Expenses**

The following prescription drugs, medications and supplies are also covered expenses under this Coverage.

## **Off-Label Use**

FDA approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in CVS Caremark's sole discretion, be subject to Prior Authorization, step-therapy or other CVS Caremark requirements or limitations.

## **Diabetic Supplies**

The following diabetic supplies upon prescription by a physician:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.

- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

## Contraceptives

Covered expenses include charges made by a network pharmacy for the following contraceptive methods when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are generic prescription drugs and brand-name prescription drugs.
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives; and.
- FDA-approved female generic over-the-counter (OTC) contraceptives.

### Important Note:

This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the CVS Caremark website at [www.caremark.com](http://www.caremark.com) or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or pharmacy plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive prescription drugs and devices that is required to be when they are provided, administered, or removed, by a physician during an office visit.

Refer to the *ACA Preventive* section of your *Schedule of Benefits* for cost-sharing information.

### Important Notes:

1. The Copay and Deductible Waiver does not apply to contraceptive methods that are:
  - FDA-approved female brand-name emergency contraceptives.
  - FDA-approved female brand-name over-the-counter (OTC) contraceptives.

However, the Copay and Deductible Waiver does apply when:

- Such contraceptive methods are not available within the same therapeutic drug class; or
  - A generic equivalent, or generic alternative, within the same therapeutic drug class is not available; and you are granted a medical exception. Refer to *Medical Exceptions* in the *Prior Authorization section* for information on how you or your prescriber can obtain a Prior Authorization.
2. A *generic equivalent* contains the identical amounts of the same active ingredients as the brand-name prescription drug or device. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

## Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a network pharmacy. They are covered when they are:

- prescribed by a physician;

- obtained at a pharmacy; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children 5 years old or younger whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Tobacco Cessation
- Vitamin D Supplements: Benefits are available to adults sixty-five years or older to promote calcium absorption and bone growth in their bodies.
- Immunization Vaccines for Children: Vaccine drug coverage only and does not cover administration of the vaccine.
- Immunization Vaccines for Adults: Vaccine drug coverage only and does not cover administration of the vaccine.
- Oral Contraceptives
- Bowel Prep Medication: Covered from age 50-74
- Risk-Reducing Breast Cancer Prescription Drugs
- Statin use for the primary prevention of cardiovascular disease in adults aged from 40-75 years old.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

### **Tobacco Cessation Prescription and Over-the-Counter Drugs**

Covered expenses include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

### **Prior Authorization**

Prior Authorization is required for certain prescription drugs. Prescribers must contact CVS Caremark or an affiliate to request and obtain coverage for such prescription drugs. The list of drugs requiring Prior Authorization is subject to periodic review and modification by CVS Caremark.

An updated copy of the list of drugs requiring Prior Authorization shall be available upon request or may be accessed on line and can be found in the CVS Caremark preferred drug guide available online at [www.caremark.com](http://www.caremark.com).

Failure to request Prior Authorization will result in reduction of benefits or denial of coverage, so be sure to ask your prescriber or pharmacist if the drug being considered requires Prior Authorization.

### **How to Obtain Prior Authorization**

If an outpatient prescription drug requires Prior Authorization and you use a network pharmacy the prescriber is required to obtain Prior Authorization for you.

CVS Caremark will let your prescriber know if the prescription drug is authorized.

If Prior Authorization is denied CVS Caremark will notify you how the decision can be appealed.

### **General Appeals Information**

*Fax:*

1-866-443-1172

ATTN: Appeals Department

*Mail:*

Caremark, Inc.

Appeals Department MC 109

P.O. Box 52084

Phoenix, AZ 85072-2084

### **Specialty Guideline Management (SGM) Appeals Information**

*Fax:*

1-855-230-5548

ATTN: Appeals Department

*Mail:*

CVS/caremark, Inc.

Specialty Guideline Management Appeals Department

800 Biermann Court Ste. B

Mt. Prospect, IL 60056

### **Generic Step-Therapy**

The CVS Health Generic Step Therapy Plan Design (GSTP) solutions help encourage the use of low-cost generics and preferred brand drugs. As part of the experience, Caremark will communicate with members to encourage behaviors that will lead to higher use of more cost-effective generics and preferred brands: an easy and effective way to improve savings for the plan and member alike.

Lists of the step-therapy drugs and prerequisite drugs are included in the CVS Caremark preferred drug guide available upon request or online at [www.caremark.com](http://www.caremark.com). The list of step therapy drugs are subject to change by CVS Caremark.

### **Medical Exceptions**

Your prescriber may seek a medical exception to obtain coverage for drugs for which coverage is denied through Prior Authorization or Step Therapy. The prescriber must submit such exception requests to CVS Caremark. Coverage granted as a result of a medical exception shall be based on an individual, case by case medical necessity determination and coverage will not apply or extend to other covered persons.

### **Pharmacy Benefit Limitations**

A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.



CVS Caremark will not reimburse you for out-of-pocket expenses for prescription drugs purchased from an out-of-network pharmacy for non-emergency prescriptions.

The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required coinsurance or deductible, or for any prescription drug for which no charge is made to you.

CVS Caremark retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet.

The number of coinsurances/deductibles you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any prescription drug dispensed by a mail order or retail pharmacy for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

### **Pharmacy Benefit Exclusions**

The plan does not cover the following expenses:

Administration or injection of any drug. Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

Diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Contraception:

- Over the counter contraceptive supplies including but not limited to:
- Male condoms;
- Contraceptive foams;
- Jellies; and
- Ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to:

- Health and beauty aids;
- Chemical peels;
- Dermabrasion;
- Treatments;
- Bleaching;

- Creams;
- Ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in Oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches).

Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes including but not limited to:

- Sildenafil citrate;
- Phentolamine;
- Apomorphine;
- Alprostadil; or
- Any other prescription drug that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes.

Drugs which do not, by federal or state law, need a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written.

Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- Stimulants;
- Preparations;
- Foods or diet supplements;
- Dietary regimens and supplements;
- Food or food supplements;
- Appetite suppressants; and
- Other medications.

Drugs used for the treatment of obesity.

All drugs or medications in a therapeutic drug class if one of the drugs in that therapeutic drug class is not a prescription drug.

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices

This exclusion will not apply with respect 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
- CVS Caremark determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

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.

**Injectables:**

- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by the Plan;
- Injectable drugs dispensed by out-of-network pharmacies;
- Needles and syringes, except for diabetic needles and syringes;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the specialty pharmacy network. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the specialty pharmacy network is available upon request or may be accessed at the CVS Caremark website at [www.caremark.com](http://www.caremark.com)
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Prescription drugs dispensed by an out-of-network pharmacy, except in a medical emergency or urgent care situation.

Prescription drugs, medications, injectables or supplies provided through a third party vendor contract with the contract holder.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet.

Refills in excess of the amount specified by the prescription order. Before recognizing charges, CVS Caremark may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen prescriptions.

Drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

Supplies, devices or equipment of any type

Test agents except diabetic test agent