GWINNETT COUNTY
DEPARTMENT OF FINANCIAL SERVICES
PURCHASING DIVISION

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January 17, 2024

Addendum #2
RP001-24
Provision of Self-Insured Medical and Pharmacy Plan Administration on an Annual Contract

Revisions

R1. Update the dates listed below in place of those listed on Page 7 of the Read Me First Document

- Peer to Peer Behavioral Health Support for First Responders – effective ~~1/1/2023~~ 1/1/2024
- Second Opinion Service – effective 1/1/2022
- Specialized Oncology Support – effective ~~1/1/2023~~ 1/1/2024
- Specialized Diabetes Management – effective ~~1/1/2023~~ 1/1/2024
- Virtual Musculoskeletal Support – effective 1/1/2022

Attachments

- 2023-2024 Summary-Plan-Description
- 2024 SBC Aetna Choice POS II – Bronze v2
- 2024 SBC Aetna Choice POS II – Gold v2
- 2024 SBC Aetna Choice POS II – Silver v2
- 2024 SBC Aetna Choice POS II – Traditional v2
- 2023 Aetna CPOSII – Booklet
- 2023 Aetna CPOSII – Bronze Plan SOB
- 2023 Aetna CPOSII – Gold Plan SOB
- 2023 Aetna CPOSII – Silver Plan SOB
- 2023 Aetna CPOSII – Traditional Plan SOB

Acknowledge receipt of this addendum on Page 16 of the proposal document.

Sincerely,

Dana Garland, CPPB, FOII, NIGP-CPP
Purchasing Division7

SUMMARY PLAN DESCRIPTION

OF THE GWINNETT COUNTY HEALTH BENEFIT PLAN

Gwinnett

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NOTICE

This document, which is called the Summary Plan Document (SPD), describes the benefits under the Gwinnett County Benefits Plan (hereinafter referred to as the Plan) as established for eligible employees, retirees, COBRA participants (and their eligible dependents) of Gwinnett County Board of Commissioners (hereinafter referred to as the Employer or Sponsor). A thorough understanding of the coverage and health benefits under the Plan will enable the employees and retirees to use their benefits most effectively.

The Sponsor hereby established the Plan based on the terms and conditions in this SPD and the incorporated documents. The incorporated documents are listed in the Active Benefits Book and the Retiree Benefits Book. You can access these Books at any time through GC Workplace, or by contacting the Plan Administrator at Benefits@GwinnettCounty.com or 770.822.7915.

You will also have access to this SPD and all Benefits Books when you are initially eligible to enroll in the Plan and again during the annual enrollment periods. This SPD is a wrap document and includes the following benefit documents for the Plan:

- Medical Plans
  - High Deductible Health Plan
  - Traditional PPO Plan (Retirees Only)
  - HMO Plan
  - Medicare Advantage Plan
- Dental Plans
  - Dental HMO (DHMO) Plan
  - Mid Option Dental
  - High Option Dental
- Vision Plans
  - Basic Vision Plan
  - Premier Vision Plan
- Spending Accounts
  - Health Savings Account (HSA)
  - Health Reimbursement Arrangement (HRA)
  - Health Care Flexible Spending Account (FSA)
  - Dependent Care Flexible Spending Account (FSA)
- Life Insurance
  - Basic Life Insurance
  - Employee Optional Life Insurance
  - Spouse Optional Life Insurance
  - Child Optional Life Insurance
- Disability Plans
  - Short-Term Disability Insurance Plan
  - Long-Term Disability Insurance Plan

- Supplemental Insurance Plans
  - Accident Insurance Plan
  - Critical Illness Insurance Plan
  - Hospital Indemnity Insurance Plan
- Maven Wallet Reimbursement Plan
- Gwinnett County Wellness Program

This SPD also includes enrollment materials and other general communications identified as containing information about benefits under the Plan, as well as pertinent contracts between the Sponsor and the claims administrators that provide services under the Plan.

These documents are incorporated into this SPD and serve as the source of specific information relating to the Plan. This SPD and the incorporated documents function as one document to summarize the Plan.

The SPD is intended to provide an easy-to-read explanation of the Plan, but it does not guarantee benefits. Every effort has been made to make this information as accurate as possible. If there is any conflict between this SPD and the incorporated documents, the incorporated documents will govern in all cases. No rights or benefits will be gained because of misstatements in, or omissions from this SPD.

Participation in the Plan does not guarantee continued employment with the Employer, nor does it altar at-will employment status. If an employee quits, is discharged or laid off, the Plan does not provide health benefits or interest, except as specifically provided in the incorporated documents and under the *Consolidated Omnibus Budget Reconciliation Act of 1985,* as amended (COBRA).

The Sponsor reserves the right to revise the Plan and the benefits provided to employees, retirees, and dependents at any time and also reserves the right to change the participant contributions for coverage under the Plan.

This SPD is effective January 1, 2024 and replaces any previous SPD for the Plan.

CAFETERIA PLAN BENEFITS

The Sponsor's benefit program is considered a cafeteria plan that qualifies under Internal Revenue Code (IRC) Section 125. This allows the employee to pay the premium contributions for these health benefits, when applicable, on a pre-tax basis. It also requires that the Employer adhere to IRC Section 125 regulations concerning such terms as when any changes are made to elections each year.

YOUR HEALTH BENEFITS & TERMS OF COVERAGE

Eligible employees of the Employer and their dependents are eligible for the following health benefits under the Plan:

- Medical Benefits, including prescription drug benefits.
- Dental Benefits
- Vision Benefits
- Health Savings Account (for those on a high deductible health plan)
- Health Reimbursement Account (for those on an HMO plan)
- Flexible Spending Accounts (restrictions apply)
- Disability Insurance
- Life Insurance
- Accident, Hospital Indemnity, and Critical Illness Insurance
- Maven Wallet Reimbursement Program
- Wellness Program, including a premium discount and a tobacco surcharge.

Eligible retirees of the Employer and their dependents are eligible for the following health benefits under the Plan:

- Retiree Medical Benefits, including prescription drug benefits.
- Dental Benefits
- Vision Benefits

The details of each of these health benefits are described in the incorporated documents.

TERMS OF COVERAGE

The Plan provides the benefits described in this SPD only for eligible participants.

Benefit payments for covered health services or supplies will be made directly to preferred, participating, or contracted providers. Payment will be made to you for covered health services or supplies from a non-preferred, non-participating, or non-contracted provider.

The Plan does not supply or recommend hospitals or physicians. Neither the Plan nor the Plan Administrator nor the claims administrators are responsible for any injuries or damages you may suffer due to actions of any hospital, physician, or other person.

In order to process claims, the claims administrators may request additional information about the medical treatment received and/or other group health coverage which you may have. This information will be treated confidentially.

An oral verification of benefits by a claims administrator's employee is not legally binding.

Any correspondence mailed to you will be sent to the most current address on file. You are responsible for notifying the Plan Administrator by contacting Human Resources or by changing your address in the HRIS system through *MyGCHub* when you have a change in address.

OUTCOME OF COVERED SERVICES AND SUPPLIES

The Employer is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies for which you receive payments under the Plan.

You are solely responsible for your choice of health care providers, services, and/or supplies. Obtaining health care and determining which provider, service, and/or supply to use shall not be construed, interpreted, or deemed as resulting from the Plan or any incorporated document.

You must make a decision as to your health care independent of any determinations to whether payment will or will not be made under the Plan for that health care. The determination of whether or not health care is medically necessary is made solely for purposes of determining whether payments for benefits will be made under the Plan and is not intended to be advice to you about your health care.

COST OF COVERAGE

You pay a portion or all of the cost of coverage and benefits, depending on the coverage or benefit, for you and your dependents under the Plan, and the Employer pays the remainder. Employees pay participant contributions by pre-tax payroll deductions. Retirees pay participant contributions on an after-tax basis, as billed. Note that the full cost of dental and vision benefits is paid by the participant.

The Plan Administrator determines the amount of participant contributions prior to each enrollment period and will provide this information to you with the enrollment materials. You may also contact the Plan Administrator to receive information about participant contributions.
Note that the cost of health coverage does not include your payments for any applicable deductibles, co-pays, coinsurance, out-of-network charges, or non-covered items.

FUNDING AND SOURCE OF CONTRIBUTIONS

The Plan is funded by participant pre-tax contributions, participant after-tax contributions, and Employer contributions. Health benefits other than insured benefits are paid from the general assets of the Employer; insured benefits are paid by the insurance companies who have entered into contracts with the Sponsor to provide those insured benefits.

Premiums for the COBRA continuation of health benefits are paid for by COBRA participants on an after-tax basis.

Any refund, rebate, dividend, experience adjustment, or other similar payment under an insurance contract will be applied first to reimburse the Employer for its contributions, unless otherwise provided in that insurance contract or required by applicable law.

PARTICIPATING PROVIDER NETWORKS AND DIRECTORIES

For health benefits provided through a network, you may obtain the participating provider directories from the claims administrator for a particular benefit, free of charge.

Newborns' and Mothers' Health Protection Act of 1996
The Newborns' and Mothers' Health Protection Act requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any length of hospital 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 caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain an authorization from the plans or the insurance issuers for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
The Women's Health and Cancer Rights Act requires the Plan to cover the following services:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

The law prohibits the Plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the Plan in order to avoid the requirements of the law.
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., physician, clinic, or hospital) to induce the provider to provide care inconsistent with the law.
- Providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the law.

Health benefits for the above services are subject to the same general provisions that apply to other services covered under the Plan, for example:

- Contracted vs. non-contracted providers; in-network and out-of-network providers, and referrals/authorizations. The coverage may be subject to annual deductible and coinsurance provisions.

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
The Mental Health Parity and Addiction Equity Act states, that with some exceptions, a group health plan that provides mental health and/or substance abuse benefits may not place special limitations on benefits related to mental health treatment or substance use disorders.

The MHPAEA states that:

- Treatment limits, such as number of days or services allowable, cannot be more restrictive than the most common or frequent limitations applied to medical and surgical benefits provided by the Plan.
- Cost-sharing features of the Plan, including deductibles, co-pays, coinsurance, and out-of-pocket expenses, cannot be more restrictive regarding mental health and/or substance abuse benefits than the most common or frequent cost-sharing features applied to medical and surgical benefits provided by the Plan.
- If the Plan offers out-of-network benefits for medical and surgical services, out-of-network benefits must also be offered for mental health and/or substance abuse disorders. The Plan offered by the Sponsor complies with the terms of the MHPAEA.

Genetic Information Nondiscrimination Act (GINA) of 2008

The Genetic Information Nondiscrimination Act prohibits discrimination on the basis of genetic information. The law states that it is illegal for group health plans and health insurers to deny coverage or charge higher insurance premiums or contribution rates to an individual found to have a genetic predisposition toward a disease or disorder. The law also makes it illegal for employers to consider an employee's genetic information when making hiring, firing, placement, or promotion decisions.

GINA prohibits:

- Access to individual genetic information by plans and insurance companies making enrollment decisions and employers making hiring decisions.
- Plans and insurance companies from discriminating against an applicant for health insurance based on genetic information, the refusal to produce genetic information, and/or for having been genetically tested in the past.
- Plans and insurance companies or employers from requesting that applicants for health insurance benefits be genetically tested.
- Employers from collecting genetic information.

- Genetic information cannot be requested, required, or purchased for underwriting purposes or to be used in determining eligibility for enrollment in the Plan. Genetic information cannot be used to adjust premiums or to determine Employer contributions for health benefits.

The Plan is allowed to request and use genetic testing results when the information is necessary to make claim payment determinations. When that is the case, only the minimum necessary information can be requested and/or used by the Plan.

HEALTH CARE REFORM

The Plan shall comply with the coverage and medical benefit provisions required by the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA").

RIGHT OF RECOVERY OR SUBROGATION

If you or your dependents have claims for damages or a right to reimbursement from a third party for any condition, illness, or injury for which benefits are paid by the Plan, the Plan has a right to recovery.

The Plan's right to recovery is limited to the amount of benefits paid by the Plan for covered medical expenses. It does not include non-medical items. Money received for future medical care or pain and suffering is not recoverable by the Plan under this provision. The Plan's right of recovery will include compromised settlements. You or your representative must inform the Plan Administrator of any legal action or settlement discussions no later than 10 days prior to settlement or beginning of a relevant trial. The Plan Administrator will then notify you of the amount it seeks to recover.

FRAUDULENT STATEMENTS

Fraudulent statements on your application or enrollment will invalidate any payment or claims for benefits and be grounds for voiding your coverage. Fraudulent statements on your application or enrollment could also be grounds for other disciplinary action, up to and including termination of employment from the Employer.

Note, however, that any retroactive cancellation of health coverage subject to the ACA will comply with the ACA's limitations and requirements for recession of coverage.

CHANGES IN COVERAGE, BENEFITS, AND/OR PARTICIPANT CONTRIBUTIONS

The Plan Administrator and the claims administrators may mutually agree to change the benefits described in this SPD. Furthermore, the Plan Administrator reserves the right to change or eliminate plans and claims administrators, change the type or level of benefit coverage, and adjust the contributions or percentages paid by employees, retirees, disabled employees, and COBRA participants. The Plan Administrator also reserves the right to add to or eliminate the type of participants eligible for coverage under the Plan.

RELIEF FROM RESPONSIBILITIES

The Employer, the Plan administrator, and the claims administrators are relieved of their responsibilities without breach if their duties become impossible to perform by acts of God, war, terrorism, fire, etc. The claims administrators will adhere to the Employer's instructions and allow the Employer to meet all of the Employer's responsibilities under applicable state and federal law.

ACTS BEYOND REASONABLE CONTROL (FORCE MAJEURE)

Should the performance of any act required by this SPD be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and nonperformance of the act during the period of delay will be excused. In such an event; however, all parties shall use reasonable efforts to perform their respective obligations.

ELIGIBILITY & ENROLLMENT

MEDICAL LEVELS OF COVERAGE – ACTIVE EMPLOYEES

- Employee Only – No dependent coverage
- Employee + Spouse –No dependent children
- Employee + Child(ren)—Employee + one or more children, no spouse
- Family—Employee, spouse, and one or more children

MEDICAL LEVELS OF COVERAGE – RETIREES

- Retiree Only—No dependent coverage
- Retiree + Spouse—No dependent children
- Retiree + Child(ren)—Retiree + one or more children, no spouse
- Family—Retiree, spouse and one or more children
- Surviving Spouse—Surviving spouses of retirees and ex-elected officials

Note: Please see the OPEB Policy for details on coverage for dependents of retirees.

YOUR COVERAGE

This SPD describes the health benefits that eligible employees may receive under the Plan. When an eligible employee enrolls in and begins participating in the Plan, the employee is also called a participant. You are an eligible employee if you are:

- Working for the Employer on a permanent full-time basis
- Working for the Employer on a permanent part-time basis and credited with at least 30 hours of service per week.
- Working for the Employer as a limited-term full-time employee
- An elected official

You are also eligible to participate in the Plan if you retire from the Employer, are eligible for retiree health benefits, and elect to continue coverage at retiree rates.

The following individuals are not eligible employees:

- Leased employees
- Independent contractors or those covered under individual employment contracts, unless the contract or agreement specifies that the individual is eligible to participate.

If you are excluded from the Employer's definition of an eligible employee, you will not be eligible for benefits under the Plan, even if a court, the Internal Revenue Service (IRS), or any other enforcement authority finds that you should be considered an eligible employee.

If you become disabled while employed by the Employer, you are eligible to continue health benefits for a maximum of two (2) years. Benefits can continue past two (2) years if your disability is total and permanent, as defined by the Social Security Administration, and if you are receiving approved disability benefits provided by the Employer.

The Plan Administrator will verify all employee and retiree eligibility.

YOUR ELIGIBILITY FOR ACTIVE MEDICAL BENEFITS UNDER THE ACA

Eligibility for active medical benefits under the Plan will be determined in accordance with the employer shared responsibility provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA").
For purposes of the ACA's employer shared responsibility provisions (under Code Section 4980H), your hours of service for active medical benefits will be credited using the look-back measurement method. Under this measurement method, you will have your hours of service measured during the Measurement Periods to determine your eligibility for medical benefits during the associated Stability Periods. You are eligible for the active medical benefits under the Plan, if:

You are expected to be a full-time employee when hired, or

- You are determined by the Employer not to be a full-time employee as of your date of hire, but are credited with an average of at least 30 hours of service per week during your Initial Measurement Period, or
- You are credited with an average of at least 30 hours of service per week during the Standard Measurement Period

Full-time means that you are reasonably expected by the Employer to be credited with an average of at least 30 hours of service per week. Employees that are hired into full-time positions will generally be eligible to enroll in medical benefits effective as of the first day of the calendar month following one full calendar month of employment. Until the employee has been employed for an entire Standard Measurement Period, his medical coverage continues, based on his being hired as a full-time employee. After a full-time employee has been employed with the Employer for an entire Standard Measurement Period, the employee's eligibility for medical benefits for each subsequent Standard Stability Period will be conditioned on the employee remaining employed with the Employer and being credited with an average of at least 30 hours of service per week during each Standard Measurement Period associated with that Standard Stability Period.

Hour of service means each hour for which you are paid, or entitled to be paid, by the Employer for the performance of duties for the Employer and each hour for which you are paid, or entitled to be paid, by the Employer for a period of time during which you perform no duties for the Employer due to vacations, holidays, illness, incapacity, layoff, jury duty, military duty, or leaves of absence.

Standard Measurement Period	October 4 through October 3 each year
Standard Stability Period	January 1 through December 31 each year. This is the year of the plan.
Initial Measurement Period	The 12-month period beginning on the first day of the calendar month coincident with or next following your date of hire.
Initial Stability Period	The 12-month period beginning on the first day of the second calendar month following the month in which your first anniversary of employment begins.

If you are a newly-hired employee and the Employer does not reasonably know if you will be credited with an average of at least 30 hours per week, here is an example of how your hours of service will initially be measured:

- You are hired on May 2, 2015. Your Initial Measurement Period will run from June 1, 2015 through May 31, 2016. Your Initial Stability Period will run from July 1, 2016 through June 30, 2017. In addition, you will be measured during the Standard Measurement Period that runs from October 4, 2015 through October 3, 2016.

Please note that special rules apply if you are a re-hired employee, have a break in service, take a leave of absence, or change your job classification. For questions regarding eligibility for coverage under the Plan, contact the Plan Administrator.

COVERAGE FOR EMPLOYEES WHO CHANGE FROM PART-TIME TO FULL-TIME

If your employment status changes from part-time (working less than 30 hours per week) to full-time, you will be eligible for benefits on the effective date of your status change. If you elect benefits, coverage will be effective the first of the month after you have been in this status for one calendar month.

COVERAGE FOR EMPLOYEES WHO ARE REHIRED

If you terminate employment and are rehired by the Employer during the same plan year and within 30 days of your prior termination of employment, you will continue to be eligible for the same pre-tax Plan elections in which you participated prior to your termination of employment.

If you are rehired more than 30 calendar days after your prior termination of employment or during a subsequent plan year, you must enroll again in the Plan to receive pre-tax benefits.

COVERAGE FOR YOUR DEPENDENTS

If you enroll for coverage under the Plan, your eligible dependents may also be enrolled in the Plan. Enrolled dependents are also called participants. The Plan Administrator will verify all dependent eligibility.

For purpose of the Plan, eligible dependents include your:

- Spouse. Note that an individual is not your spouse if:
  - You and the individual are legally separated, divorced, or have obtained an annulment.
  - The individual is considered a spouse by common law (unless grandfathered by the Employer prior to January 1, 1997)
- Children, until attaining age 26. This includes biological children, stepchildren, legally adopted children (from the date you assume documented legal responsibility), and children for whom you have legal guardianship.
- Children who are mentally or physically disabled and totally dependent upon you for support, regardless of age, provided that the disability began prior to age 26. Documentation necessary to certify the disability will be determined by the Plan

Administrator. You must contact the Plan Administrator and provide the required documentation within 30 days of the child attaining age 26.

- Children for whom health coverage is required though a qualified medical child support order ("QMCSO")

ENROLLMENT IN THE PLAN

You may enroll in the Plan using the enrollment procedures established by the Plan Administrator. The Plan Administrator will notify you about the enrollment procedures prior to each enrollment period.

Newly-hired employees must enroll in the Plan within 30 calendar days of their date of hire. Coverage will be effective on the first day of the calendar month following one full calendar month of employment. If you intend to waive coverage for any or all of the offered benefits, you must still complete enrollment, indicating that you are waiving benefits. If you do not enroll when first eligible, you will not be able to enroll until the next annual enrollment period, unless a Life Status Change occurs. See Life Status Change for details.

Every year, the Plan Administrator will designate an annual enrollment period during which you may elect benefits under the Plan for the following plan year if you were not previously enrolled in the Plan or during which you may change your benefit elections if you were previously enrolled in the Plan. Note however, new elections must be made during each annual enrollment period for FSA contributions for the next plan year. Coverage will be effective on the first day of January of the following plan year. If you intend to waive coverage for any or all of the offered benefits, you must still complete enrollment, indicating that you are waiving benefits. If you do not make an election during the annual enrollment period, you will not be able to enroll until the next annual enrollment period, unless a Life Status Change occurs. See Life Status Change for details.

For other qualifying events (divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

DOCUMENTATION FOR YOUR DEPENDENTS

You are required to substantiate the eligibility of your dependents who are enrolled in the Plan. If documentation is not submitted and validated for your dependents, you will have Employee Only coverage as of your effective date.

The following is a list of documentation required for each dependent (spouse or child):

- Spouse documentation: Two (2) forms of documentation are required to enroll a spouse for coverage
  - A photocopy of a certified marriage certificate

  AND One of the following:
  - Current joint mortgage or rental contract or statement with both you and your spouse's name
  - Current joint bank account statement showing both you and your spouse's name at the same mailing address.
  - Current joint credit card statement showing both you and your spouse's name at the same mailing address.
  - Most recent year's signed federal income tax return (without supporting schedules and attachments), with both you and your spouse's name.

Please contact the Plan Administrator if you do not have any of the listed documents. Before sending one of these documents to the Plan Administrator, you should block out (or otherwise remove) any information that is not necessary for the purpose of verifying eligibility, including dollar amounts, Social Security Numbers, and account numbers. Note: "current" means dated within the last six (6) months.

- Dependent Child documentation: A copy of only one of the following documents with your name and/or that of your spouse as the parent is required:
  - Copy of certified birth certificate
  - Legal Guardianship/Custody: Final Decree with presiding judge's signature and seal
  - Final Adoption Decree with presiding judge's signature and seal

- For newly-adopted children, the effective date of coverage will be the earlier of the following events:
  - The date of legal placement for adoption, during which you have been determined legally responsible for providing the child's health coverage.
  - The Final Adoption Decree with the presiding judge's signature and seal

Regardless of which date applies, the child must be enrolled within 30 days of that date in order for coverage to be effective.

- Documentation of disabled child status (age 26 and older): In addition to the documentation required to cover a dependent child, for a disabled child who is over the age of 26, one of the following must be submitted:
  - Photocopy of the Social Security disability award, or
  - If a disability ruling by the Social Security Administration is pending, a copy of the application for disability.

ALTERNATE DEPENDENT DOCUMENTATION

Valid copies of the documentation listed above will be adequate. However, if any of the above documentation is not available in a timely fashion (e.g., in the event of a birth or marriage abroad), consideration will be given to other forms of documentation when accompanied by a signed letter from you explaining why the requested documentation is not readily available. Alternate documents must be from third-party organizations, such as governments, businesses, or religious organizations. The documents must indicate that the marital or parental relationship exists. Examples include hospital records, church records, school records, immigration records, contracts, etc. Contact the Plan Administrator for assistance.

STATE REQUIRED DOCUMENTATION

To be eligible for coverage under the Plan, you and your dependents who are 18 years of age or older must complete and submit an "Affidavit Verifying Eligibility Status of Public Benefit Applicant" form to the Benefits Office of the Department of Human Resources. This is pursuant to the Georgia Security and Immigration Act of 2006, which requires every agency administering or providing public benefits to be responsible for determining U.S. citizenship or lawful alien status. You may contact the Benefits Office for a copy of this form.

PROCEDURES FOR SUBMISSION OF DEPENDENT DOCUMENTATION

Upon final completion of the enrollment process, you should print and review a confirmation statement to assure accuracy of your enrollment. You may then attach copies of required dependent documentation to a copy of the confirmation statement and send it to the Benefits Office of the Department of Human Resources. Clear copies of the documents will be adequate. Documents will not be returned. Documents must be received in the Benefits Office within 30 days of hire or the date the benefits will become effective for you and your dependents.

Upon receipt, documents will be reviewed within five (5) business days by designated Department of Human Resources staff. If the documentation is deemed adequate, no further action is necessary. When your dependents have been validated, the documentation will not be retained.

If the documentation is deemed inadequate, Department of Human Resources staff will request additional documentation or clarification from you. If the documentation leads to the conclusion that a dependent is ineligible, the staff will request authorization from the Benefits/Retirement Plan Manager to deny enrollment of the dependent. Immediately upon denial of eligibility of any dependent, the staff will mail a letter to your home address, explaining the reasons for the denial and offering a 30-day opportunity for you to appeal by submitting specified additional documentation.

All coverage for dependents ruled ineligible will be suspended until an appeal is processed and approved. Documentation for invalidated dependent(s) will be retained.

You may appeal the eligibility denial by filing the acceptable additional documentation within 30 days of the date of the denial letter. If the Department of Human Resources staff determines that the dependent eligibility cannot be validated, there will be an automatic appeal to the Benefits/Retirement Plan Manager. If the Benefits/Retirement Plan Manager upholds the denial, you may file a final appeal, in

writing, to the Director of Human Resources within 60 calendar days of the date of the denial letter sent via certified mail. The letter must clearly explain any extenuating circumstances that result in your inability to provide adequate documentation, and any available documentation not yet provided should be attached. Upon review of the entire file, the Director of Human Resources will make a final ruling or may issue an extension of time for you to obtain complete documentation.

If the appeal is approved, coverage for the dependent will be effective retroactive to the date of your coverage. Associated participant contributions will be collected from you through payroll deductions.

LIFE STATUS CHANGE

Except for during the annual open enrollment process, you are not able to add or delete coverage for yourself or your dependents. However, you can make changes to your election during the plan year if:

- You experience a Life Status Change, have a special enrollment right, or experience another change in circumstances.
- That event or other change affects the eligibility for benefits under the Plan for either you or your dependents, as determined by the Plan Administrator.
- The modification in your election is due to and consistent with the event or other change, as determined by the Plan Administrator.

A Life Status Change is one of the following situations that occurs mid-plan year:

- Change in legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment.
  - In the case of divorce, the former spouse is no longer an eligible dependent under the Gwinnett County health plan. For purposes of employee benefits, where there is a covered spouse, the notice of divorce must be reported to Human Resources within 30 days of the event. Failure to remove divorced spouse from coverage within 30 days of the divorce event will result in the employee reimbursing Gwinnett County to recover any employer premium paid for the total number of months the divorced spouse remained covered on the Plan. The employee may also be subject to disciplinary action, up to and including termination.

- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent. This includes a dependent who becomes an eligible employee of the Employer.
- Change in employment status, including termination or commencement of employment of you, your spouse, or other dependent.
- Changes in work schedule, including an increase or decrease in the number of hours of employment by you, your spouse, or other dependent (including a transition from full-time or part-time status, a strike or lockout, or commencement or return from an unpaid leave of absence)
- Your dependent satisfies or ceases to satisfy the requirements/definition of a covered dependent, as required by the Plan through which you are covered, by any means such as attainment of age or similar circumstances.

- A change in the place of residence or work site of you, your spouse, or other dependent that affects eligibility for health benefits.
- A Qualified Medical Child Support Order (QMCSO) requiring you to cover your dependent child becomes effective or expires.
- Enrollment in or loss of eligibility for Medicare or Medicaid
- Eligibility for premium assistance, with respect to coverage under the Plan, or loss of coverage under Medicaid or an S-CHIP plan. You must enroll yourself and/or your dependent for coverage within:
  - 60 calendar days of when coverage under Medicaid or an S-CHIP plan ends
  - 60 calendar days of the date you or your dependent becomes eligible for Medicaid or S-CHIP premium assistance
- Change in Cost. If you are notified that the cost of coverage under the Plan significantly increases or decreases during the plan year, you may make a corresponding change in your elections under the Plan. You may commence participation in Plan option with a decrease in cost; or, in the case of an increase in cost, you may choose to: (1) make an increase in contributions; or (2) revoke coverage and elect another Plan option that provides similar coverage; or (3) drop Plan coverage if there is no other Plan option that provides coverage similar to the existing coverage (This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed (e.g., a provider network ceases to be available to you), you may revoke your election and elect coverage under another Plan option that provides similar coverage. If, during the plan year, the Plan eliminates a coverage option, you may revoke coverage and elect another Plan option that provides similar coverage or drop Plan coverage if there is no other Plan option that provides coverage similar to the existing coverage. If the Plan adds a new Plan option, or if coverage under an existing Plan option is significantly improved during a plan year, you may elect the newly-added Plan option or the improved Plan option, whether or not you previously made an election under the Plan, and may do so on a pre-tax basis (This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Change in Coverage Under Another Employer Plan. You may make a change that is due to, and corresponds with, a change to your spouse's or other dependent's employer plan, as long as: (a) that employer's plan permits its participants to make a change permitted under the IRS regulations; or (b) the Plan permits you to make an election for a period of coverage which is different from the period of coverage under your spouse's or other dependent's employer plan(This "Change in Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)
- Loss of Other Coverage. You may elect to add coverage under the Plan for you, your spouse, or your other dependents if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (1) a state's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (2) a medical care program of an Indian Tribal government (defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; (3) a state health benefits risk pool; or (4) a foreign government group health plan (This "Change in

Coverage" exception is not applicable to the Health Care Flexible Spending Account under the Plan.)

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), gives you additional flexibility in whom you can enroll for the benefits under the Plan due to marriage, birth, adoption, or placement for adoption:

- Non-enrolled employee: If eligible but not enrolled, you can enroll as of the date of the event.
- Non-enrolled spouse: If you are enrolled, you can enroll your spouse upon marriage. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption. If you are not enrolled, you must also enroll.
- Non-enrolled dependents: You can enroll your dependent children as the result of an event. However, if you are not enrolled, you must also enroll.

In addition, HIPAA provides you with special enrollment rights in the event of the following events:

- You elected "no coverage" under this Plan because you had health coverage elsewhere (for example, under a spouse's plan) and that other health coverage ends later
  - The other health coverage must end because of a loss of eligibility, such as a divorce; termination of employment; the other employer stops offering its plan to the eligible class to which you belong; the other employer stops contributing to its plan; or you or your dependent(s) no longer reside, live, or work in the other plan's network service area and no other health coverage is available under the other plan
  - You cannot make an election change during the plan year if your other health coverage is lost because of something you do or do not do, such as not making your required contributions.
- Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") continuation coverage from another employer for you or your dependent is exhausted.

The Plan Administrator must be notified, in writing, within 30 calendar days of the Life Status Change in order for the change to be effective. If approved, the change in benefits and/or coverage will be effective the day of the event.

MEDICAL CHILD SUPPORT ORDERS ("MCSO") OR NATIONAL MEDICAL SUPPORT NOTICES ("NMSN")

A MCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). An NMSN is an exclusive document that state child support enforcement agencies are required to use when enforcing the health coverage provisions of medical child support orders. Neither of these orders can require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child's health coverage.

An order may require health coverage under the Plan for your child even if you are divorced, your ex-spouse has legal custody of your child, and your child is not dependent on you for support. The order also gives you a special enrollment right to add coverage outside of any annual open enrollment period restrictions.

If the Employer receives a valid order, you may enroll your dependent child for health benefits under the Plan pursuant to the order's terms. The change you elect takes effect as of the date the order is processed. If the Employer receives a valid order and you do not enroll your dependent child for health benefits under the Plan pursuant to the order's terms, the Plan will provide health benefits for your child in accordance with the terms of the order. The cost of coverage provided pursuant to the order will be automatically withheld from your pay, subject to any limits set by state or federal law.

Note that, if you are not enrolled in the Plan, you must also enroll when your dependent child is enrolled under a valid order.

Federal law requires that a MCSO must meet certain form and content requirements to be valid. When processing and administering benefits under an NMSN, the Plan Administrator must also comply with the law's general MCSO requirements. Thus, the Employer follows certain procedures to determine if a MCSO or a NMSN is valid. You may request, without charge, a copy of the Plan's administrative procedures for processing orders from the Plan Administrator. If you become subject to an order, you will receive a copy of these administrative procedures, free of charge, from the Plan Administrator.

TERMINATION OF COVERAGE

You may continue to participate in the Plan as long as you meet the Plan's eligibility requirements. Participation ceases if your employment ends or if you fail to make any required participant contribution. In either instance, coverage will end on the last day of the calendar month in which the termination occurred or at the end of the period covered by your last participant contribution. In addition:

- Coverage of your enrolled child ceases at the end of the month in which your child attains age 26
- Coverage of your disabled child over age 26 ceases if your child is found to be no longer totally or permanently disabled.
- Coverage of your spouse will end the last day of the month in the month in which you and your spouse are divorced.

If you or your dependent is receiving covered care in the hospital at the time participation terminates for reasons other than your cancellation of the Plan or failure to pay the required participant contributions, benefits for hospital inpatient care will be provided only to the extent available for that hospital stay.

COORDINATION OF BENEFITS

Health benefits under the Plan will be coordinated with other group plans covering you and your dependents.

If you are covered under another group health care plan (as the primary plan), health benefits under the Plan will be coordinated with any benefits payable under that other plan so that no more than 100 percent of the total billed or allowable charges will be paid. Payment under the Plan will be reduced by payments made under the other plan, but the Plan will pay up to 100 percent of the allowable amount.

Coordination examples:

- Your spouse is covered under her employer's health care plan. Her plan has an office visit co-pay of $25. If the plans also have an office visit co-pay of $25, the plans would pay nothing.
- Your spouse is covered under her employer's health care plan. Her plan has an inpatient co-pay of $500, balance paid at 100 percent. If the Plan has an inpatient co-pay of $200, this Plan would pay $300.

It is your obligation to supply requested information for all plans (copies of Explanation of Benefits from the other plan). Failure to do so may result in claim denials or delay in the processing of your claim.

Group plans include:

- Plans sponsored by other employers
- Governmental programs of health care
- Collectively bargained plans
- Employee or employer organization plans

HOW COORDINATION OF BENEFITS WORKS

A plan without a coordinating provision is always the primary plan. If all plans have a coordinating provision:

- The plan covering the patient as an employee, rather than as a dependent, will be the primary plan
- If a child is covered under both parents' plan, then the plan covering the parent whose birthday occurs earlier in the year will be primary
- **In the case of a dependent child whose parents are divorced:**
  - The parent with legal custody of the child is primary/
  - If the custodial parent is remarried, the custodial parent's health coverage is primary. The non-custodial parent's health coverage is second, and the stepparent's health coverage is third.

Exception: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then that parent's policy would be primary.

- An active plan (one in which an employee is currently working) is primary over an in-active plan (a plan that a person might have as a retiree or inactive employee)
- If none of the previous rules determine primacy, the plan covering the person longer is the primary plan.

By applying for, paying participant contributions for, or accepting benefits under the plans, you agree that the claims administrators, in order to administer claims, have the right to:

- Obtain or share data needed to determine benefits under this or any other provision of the plans.
- Recover any sum paid above required by this or any other provision of the plans, from another plan which is liable for such amount but has not yet paid, or from you by request, by legal proceeding, or by withholding such amounts from future payments.

IF YOU ARE ELIGIBLE FOR MEDICARE AS AN ACTIVE EMPLOYEE

If you are covered under the Plan for health care benefits and are also eligible for Medicare benefits or have dependents who are Medicare-eligible:

- Due to end stage renal disease, the Plan will determine benefits without taking into account Medicare benefits for which that person is eligible during the first 30 consecutive months that person is eligible for Medicare benefits.
- Due to attainment of age 65, the plans will determine benefits without taking into account Medicare benefits.

RETIRED EMPLOYEES AND DEPENDENTS FOR WHOM MEDICARE IS THE PRIMARY PLAN

If you are retired and have attained age 65, Medicare is your primary plan, and you must enroll in Medicare, both Part A and Part B in order to be eligible for the Medicare Plans offered by the Employer.

CONTINUING COVERAGE

LEAVES OF ABSENCE

Generally, your health benefits do not continue while you are on a leave of absence, unless that leave is a military leave or an FMLA leave, as discussed below. Contact the Plan Administrator for additional information.

Uniformed Services Employment and Re-Employment Rights Act of 1994

The Uniformed Services Employment and Re-employment Rights Act, as amended (USERRA), requires the Plan to continue health coverage for a participant who is on a military leave of absence, as described below. These requirements apply to the health benefits provided for you and your dependents.

CONTINUATION OF COVERAGE:

You may elect to continue your health coverage for yourself and your dependents. For military leaves of less than 31 days, you will pay for your health benefits as if you were still at work. For military leaves of 31 days or more, the following applies:

- You may continue coverage by paying the required participant contributions to the Employer, until the earliest of the following:
  - 24 months from the last day of employment with the Employer
  - The day after you fail to return to work
  - The day the Plan terminates.
- The Employer will charge you up to 102 percent of the total cost of the health coverage.

REINSTATEMENT OF BENEFITS:

If your health benefits end during the military leave because you do not elect coverage under USERRA and you are rehired by the Employer, health benefits for you and your dependents will be reinstated if:

- You gave the Employer advance written or verbal notice of your military leave.
- The duration of all military leaves while you are employed with the Employer does not exceed Five years.

You and your dependents will only be subject to the balance of a waiting period, if appropriate, that was not yet satisfied before the military leave began. However, if an injury or illness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your health coverage under the Plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before active duty commences, these reinstatement rights will continue to apply.

Contact the Plan Administrator for more information about continuing health benefits during a military leave of absence.

Family and Medical Leave Act
Your health benefits will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA). The Plan Administrator will give you more detailed information about the FMLA. The FMLA allows you to take a leave of absence for up to a total of 12 work weeks in a 12-month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child.
- The placement of a child with you for adoption or foster care
- To care for a family member (child, spouse, or parent) with a serious health condition
- Your own serious health condition that makes you unable to perform the functions of your job.
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the Armed Forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the Armed Forces with a serious injury or illness.

HEALTH BENEFITS COVERAGE WHILE ON FMLA LEAVE:
The Employer will continue your health benefits under the Plan during your FMLA leave just as if you were still employed. The cost of health coverage during an FMLA leave must be paid, and you must make all required participant contributions on an after-tax basis in accordance with the agreement reached between you and the Employer prior to the FMLA leave becoming effective. Alternatively, the Employer may collect the participant contributions in arrears after you return to work from FMLA leave.

A newly-acquired dependent is eligible for health coverage while your coverage is continued during an FMLA leave.

Continued health coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.
- Exhaust your approved period of FMLA leave and do not return to work from the FMLA leave.

If your employment does not terminate during your FMLA leave, but you do not return to work once your FMLA leave ends, you can choose to continue health benefits under the COBRA continuation rules.
Reinstatement of Canceled Coverage Following FMLA Leave:
Upon your return to employment following an FMLA leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any waiting period, if appropriate, to the extent that it had been satisfied prior to the start of the FMLA leave.

STATE FAMILY AND MEDICAL LEAVE LAWS:
The Employer's FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

IF THE EMPLOYER CHANGES BENEFITS:
If the Employer offers new benefits or changes its benefits while you are on an FMLA leave, you are eligible for the new or changed benefits, but participant contributions for those benefits may increase.

EXTENDED MEDICAL LEAVE:
At the discretion of the County, employees may be eligible for extended medical leave. Please contact the Department of Human Resources for more information.

CLAIMS & APPEALS

CLAIMS FILING

Each participant enrolled under the Plan receives an identification card. When using a preferred or contracted medical provider or when admitted to a preferred or contracted hospital, you must present your identification card. Upon discharge, you will be billed only for those charges not covered by the Plan. The preferred or contracted provider or hospital will bill the claims administrator directly for covered services. Payment for covered services will be made directly to the preferred or contracted provider or hospital.

If you use a non-preferred or non-contracted medical provider or are admitted to a non-preferred or non-contracted hospital that does not have a participating agreement with the claims administrator, you should inform the admitting personnel of your coverage. You must submit the bill to the claims administrator.

For health care expenses other than those billed by a preferred or contracted provider, you must use the claims forms available online, at the claims administrator's websites. Claims should include your name, identification, and group numbers exactly as they appear on your identification card. You must attach itemized bills to the claim form and file them directly with the claims administrator. You should keep a photocopy of all forms and bills for your records. The address to mail claims is on your medical ID card. You must make certain that the claim information is itemized to include dates, places, diagnoses, and nature of services or supplies.

TIMELINESS OF FILING

To receive benefits, a properly completed claim form, with any necessary reports and records, must be filed within 12-months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless there is incomplete or missing information. In this case, you will be notified of the reason for the delay. After this data is received, the claims administrator will complete claims processing.

NECESSARY INFORMATION

In order to process a claim, the claims administrator may need information from the provider of the service. You must agree to authorize the physician, hospital, or other provider to release necessary information. The claims administrator will consider such information confidential.
However, both the Plan and the claims administrator have the right to use this information to defend or explain a denied claim.

UNAUTHORIZED USE OF IDENTIFICATION CARD

If you permit your identification card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Unauthorized use could also result in termination of the coverage.

QUESTIONS ABOUT COVERAGE OR CLAIMS
If you have questions about coverage or claims, you should contact the claims administrator's customer service department. The Employer does not receive claim payment information from the claims administrator and cannot explain the processing of any claims. When contacting the claims administrator, you should be prepared to provide the information available on your identification card.

When asking about a claim, you must provide the following information:

- Your identification and group number
- Date of service
- Provider name (hospital or physician)

To find out if a medical provider is a preferred or contracted provider, you should consult the claims administrators' websites or call the claims administrators.

DETERMINATION OF ELIGIBILITY CLAIMS OR BENEFIT CLAIMS
There are two types of claims:

- Eligibility and enrollment claims – A claim to participate or enroll in the Plan or to change an election to participate mid-year.
- Benefit claims – A claim for a specific health benefit, which typically includes the initial request for benefits.

DETERMINATION OF ELIGIBILITY AND ENROLLMENT CLAIMS
All claims regarding your or your dependent's eligibility and enrollment for health benefits under the Plan are determined by the Plan Administrator, in its sole discretion.

DETERMINATION OF BENEFIT CLAIMS AND APPEALS
All benefit claims and appeals for the health (medical, dental, and vision) benefits offered under the Plan are determined in accordance with the claims and appeals procedures described below.

LEGAL ACTION
The claimant has the right to bring a civil action if he/she is not satisfied with the outcome of the claims and appeals procedure. The claimant may not initiate a legal action against the Plan until he/she has completed the claims and appeals process.

AUTHORIZED REPRESENTATIVE
A claimant may have an authorized representative act on his/her behalf with respect to a benefit claim or appeal by notifying the claims administrator in writing. The claims administrator will recognize a court order giving a person authority to submit claims and appeals on the claimant's behalf. The claims administrator may also recognize providers as authorized to act on the claimant's behalf under its procedures.

In the case of an urgent care claim or appeal, the claims administrator will automatically recognize a health care professional with knowledge of the claimant's medical condition (for example, the treating

physician) as his/her authorized representative, unless the claimant gives the claims administrator other instructions in writing.

Once the claimant has an authorized representative, the claims administrator will direct all information, notifications, etc. regarding the claim or appeal to the authorized representative. The claimant will receive copies of all notifications regarding decisions, unless he/she gives the claim administrator other instructions in writing.

Once the claimant has an authorized representative, all references in these claims and appeals procedures to "claimant" will include the authorized representative, where appropriate. An assignment for payment does not constitute an appointment of an authorized representative under these claims and appeals procedures.

Types of Benefit Claims
There are four types of health benefit claims, each with different time limits:

- Pre-service claims (other than urgent care claims): This is a claim for benefits under the Plan where the Plan requires that, to receive benefits from the Plan, in whole or in part, the claimant must obtain approval before receiving treatment or care.
- Urgent care claims: This is a pre-service claim for benefits that, if not decided quickly, could seriously jeopardize the claimant's life or health or ability to regain maximum function or would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the benefits that are the subject of the claim.
- When the claims administrator receives a pre-service claim, they will decide whether it involves urgent care. A person acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will make this determination. However, if a physician with knowledge of the claimant's medical condition tells the claims administrator that the claim involves urgent care, the claims administrator will treat the pre-service claim as an urgent care claim.
- Post-service claims: This is a claim for benefits under the Plan after the claimant has received the benefits. Claims filed one year or more after the date of service will not be paid unless the claimant has proof of timely filing.
- Concurrent care claims: The Plan makes a concurrent care decision when they approve an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. If the claimant has been approved for an ongoing course of treatment, he/ she will be notified in advance if the approved course of treatment is intended to be terminated or reduced. The claimant will be provided with the notice in sufficient time to allow him/her the opportunity to appeal the decision and receive a decision on appeal before the termination or reduction takes effect.

If the claimant would like to extend an ongoing course of treatment that is a claim involving urgent care, a claim for such extension should be filed at least 24 hours before the end of the initially approved period of time or number of treatments.

Notifications for Benefit Claims

- Incorrectly filed pre-service (including urgent care) claims: If the claimant does not follow the correct procedures for filing a pre-service claim (including an urgent care claim), the claims administrator will notify him/her as soon as possible, but no later than five days after they receive the incorrectly filed pre-service claim and no later than 24 hours after it receives the incorrectly filed urgent care claim. The notification will describe the proper procedures for filing the claim
- Timing of initial claims determination: The claimant will receive a written decision from the claims administrator regarding the claim as follows:
  - Urgent care claims: The claimant will receive a decision as soon as possible, taking into account the medical urgency, but no later than 72 hours after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part. If it is determined that additional information is needed to process the claim, the claimant will be notified and told the specific information needed no later than 24 hours after the claims administrator receives the claim. The claimant will have at least 48 hours to provide the requested information. The claimant will be notified of a decision as soon as possible, but no later than 48 hours after the requested information is received or, if earlier, the end of the deadline for providing the requested information. Because of the urgency of these claims, notice of a decision may be given verbally and followed up in writing no later than three days after the verbal notice
  - Pre-service claims and post-service claims: For a pre-service claim, the claimant will receive a decision within a reasonable time appropriate to the medical circumstances, but no later than 15 days after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part. For a post-service claim, the claimant will receive a decision within a reasonable time, but no later than 30 days after the claims administrator receives the claim, whether the claim is approved or denied, in whole or in part.

If the claims administrator needs more time to process a pre-service claim or a post-service claim because of matters beyond the claims administrator's control, they may extend the initial period (15 days for a pre-service claim or 30 days for a post-service claim) for up to additional 15 days by notifying the claimant of the extension before the end of the initial period. The extension notice will explain the reason for the extension; the date the decision is expected to be made; and, if the extension is needed because the claimant did not submit information necessary to process the claim, the additional information needed. If the claimant is requested to provide additional information to process the claim, he/she will have at least 45 calendar days to provide the information. The days from the date the claimant is sent the extension notice to the due date for the requested information (or, if earlier, the date he/ she responds to the request) are not counted as part of the time period by which the claims administrator must make a decision.

- Concurrent care claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, the claimant will receive a decision as soon as possible, taking into account the medical urgency, but no later than 24 hours after the claims administrator receives the claim, regardless of whether the claim is approved or denied, in whole or in part, provided the claimant files the claim at least 24 hours before the end of the initially approved period of time or number of treatments.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for urgent care claims, pre-service claims, and post-service claims.

- Notice of determination: If the claim is approved, the claims administrator will notify the claimant in writing, and he/she will receive an Explanation of Benefits as the notification. If the claim is denied, in whole or in part, the written notice will explain:
- The specific reason(s) for the denial
- References to the specific Plan provisions on which the denial was based.
- Any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- For medical claims, information sufficient to identify the claim– Any internal procedures or clinical information upon which the denial was based (or a statement that this information will be provided free of charge, upon request)
- If the denial is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances (or a statement that this explanation will be provided free of charge, upon request)
- A description of the Plan's appeal procedures and time limits applicable to such procedures (in the case of an urgent care claim, a description of the expedited review process), and the Plan's external review procedures, including a statement of the claimant's rights to bring a civil action following an adverse benefit determination on appeal.

APPEAL PROCESS FOR BENEFIT CLAIMS
Note that the following appeal process is for self-funded health benefits offered by Aetna, as well as dental and vision claims. Details regarding the appeal process for fully-insured medical and pharmacy benefits can be found in the incorporated documents.

Claimants have the right to file an appeal with the claims administrator following any adverse benefit determination, including any rescission of medical coverage.

Appeals will only be accepted by the claims administrator. The claims administrator's decisions are final, and the Employer will not review appeals regarding benefit claims, medical necessity, procedures or treatments considered experimental in nature, and/or non-FDA approved treatments or medications under the Plan.

The claimant must make a written appeal to the claims administrator within 180 days following receipt of an adverse benefit determination. Failure to comply with this important deadline may cause the claimant to forfeit any right to any further review of the claim under these procedures or in a court of law.

If the claim involves urgent care, the claimant may appeal the claim denial either verbally or in writing. All necessary information, including the appeal determination, will be communicated between the claimant and the claims administrator by telephone, facsimile, or other similar method and followed-up with written communication.

The appeal should include the group name, the claimant's name, and the ID number or other identifying information shown on the front of the Explanation of Benefits, as well as the following:

- The reasons for the appeal
- Any written comments, documents, records, or other information supporting the appeal, whether or not submitted in connection with the initial claim.

The claims administrator may call the claimant to obtain medical records and/or other pertinent information in order to respond to the appeal.

If requested, the claimant will be given reasonable access to, and copies of, all documents, records, or other information relevant to the claim, free of charge, and the identity of any medical expert consulted in connection with the initial claim (regardless of whether the expert's advice was used to deny the claim).

Upon receipt of the appeal, the claims administrator will make a full and fair review of the claim, taking into account all comments, documents, records, and other information submitted by the claimant (regardless of whether the information was submitted or considered in determining the initial claim). The review will not defer to the claims administrator's prior decision and will not be conducted by the person(s) who made the prior decision or his/her subordinate. If the claims administrator's claim denial was based on medical judgment, the claims administrator will consult with a medical professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with its prior decision nor a subordinate of any such person. Before the claims administrator makes their appeal determination for a medical claim, the claimant will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the claims administrator (or at the direction of the claims administrator) or any new or additional rationale as soon as possible and in sufficient time to allow the claimant the opportunity to respond before the claims administrator issues its appeal determination.

TIMING OF APPEALS DETERMINATION

The claimant will receive a written notice from the claims administrator regarding the appeal as follows:

- Urgent care claims: The claimant will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after the claims administrator receives the appeal, regardless of whether the claim is approved or denied, in whole or in part. Because of the urgency of these claims, the claimant may receive notice of an appeal determination verbally and followed up in writing no later than three (3) days after the verbal notice.

- Pre-service claims (other than urgent care claims): The claimant will be notified within a reasonable time appropriate to the medical circumstances, but no later than 15 days after the claims administrator receives the appeal, regardless of whether the appeal is approved or denied, in whole or in part.
- Post-service claims: The claimant will be notified within a reasonable time, but no later than 30 days after the claims administrator receives the appeal, regardless of whether the appeal is approved or denied, in whole or in part.
- Concurrent care claims: For a claim to extend an ongoing course of treatment that is a claim involving urgent care, the claimant will be notified as soon as possible, taking into account the medical urgency, but no later than 36 hours after the claims administrator receives the appeal.

Any other request to extend an ongoing course of treatment will be decided according to the applicable time limits for pre-service claims (no later than 15 days after the claims administrator receives the appeal) and post-service claims (no later than 30 days after the claims administrator receives the appeal).

NOTIFICATIONS FOR APPEALS

If the appeal is approved, the claims administrator will notify the claimant in writing. If the appeal is denied, in whole or in part, the written notice will explain:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the adverse benefit determination was based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
- For medical claim information sufficient to identify the claim
- Any internal procedures or clinical information upon which the adverse benefit determination was based (or a statement that this information will be provided free of charge, upon request)
- If the adverse benefit determination is based on a medical necessity, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to the medical circumstances (or a statement that this explanation will be provided free of charge, upon request)
- The Plan's available review procedures, including information about the Plan's external review procedures. The notice will also state that the claimant have the right to bring a civil action after the claims and appeals process is exhausted

EXTERNAL REVIEW PROCESS

The claimant may request external review of any final adverse benefit determination that qualifies as set forth below. Subject to verification procedures that the claims administrator may establish, an authorized representative may act on the claimant's behalf in requesting and pursuing external review.

Requesting external review will have no effect on the claimant's rights to any other benefits under the Plan. External review is voluntary, and the claimant is not required to undertake it before pursuing legal

action. If the claimant chooses not to request external review, the Plan will not assert that the claimant has failed to exhaust his/her administrative remedies because of that choice.

The external review process gives the claimant the opportunity to have a review of the claims administrator's or Appeals Committee's determination on the appeal conducted pursuant to applicable federal law. The request will be eligible for external review if the following are satisfied:

- The Plan's internal claims and appeals processes have been exhausted; or The Plan's internal claims and appeals processes are deemed exhausted, as discussed above.
- The claim involves either (a) a medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). Medical judgment includes, but is not limited to, determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit or the Plan's determination that a treatment is experimental or investigational.
- The claim is not for a denial of coverage based upon the claimant's eligibility for Plan participation.

The written notice that the claimant receives regarding the claims administrator's or Appeals Committee's adverse benefit determination on the appeal will describe the process to follow if the claimant wishes to request an external review and will include a copy of the Request for External Review form.

The claimant must submit the Request for External Review form to the claims administrator within four (4) months after he/she receives notice of the claims administrator's or Appeals Committee's adverse benefit determination on appeal. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. The claimant also must include a copy of the claims administrator's or Appeals Committee's determination and all other pertinent information that supports the request for external review.

If the claimant requests external review, any applicable statute of limitations will be tolled while the external review is pending.

PRELIMINARY REVIEW:
Within five (5) business days after the claims administrator receives the Request for External Review form, it will conduct a preliminary review to determine the following: the claimant was covered under the Plan at the time the health benefit was requested or provided, the determination does not relate to eligibility for Plan participation, the claimant has exhausted the internal claims and appeals process (unless "deemed exhaustion" applies), and the claimant has provided all paperwork necessary to complete the external review.

Within one (1) business day after completion of the preliminary review, the claims administrator will issue the claimant a written notice of their determination. If the Request for External Review form is complete but not eligible for external review, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866.444.EBSA

[866.444.3272]). If the Request for External Review form is not complete, the notice will describe the information or materials needed to make the request complete, and the claimant will have until the later of the four (4)-month filing period, or the 48-hour period after he/she receives the notice, to submit the information or materials.

Referral to Independent Review Organization (IRO):
If the claims administrator determines that the request is eligible for external review, the claims administrator will assign an Independent Review Organization ("IRO"), accredited as required under federal law, to conduct the external review. The Plan must contract with at least three (3) IROs for assignments under the Plan and rotate review assignments among them. The IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review and will provide an opportunity for the claimant to submit in writing, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. Within five (5) business days after the assignment to the IRO, the claims administrator will provide the IRO with all documents and information that the claims administrator or Appeals Committee considered in making its decision on the appeal.

If the claims administrator fails to provide the documents within the five (5)-day period, the IRO may unilaterally terminate external review and make a decision to reverse the claims administrator's or Appeals Committee's adverse benefit determination. If the IRO makes the decision to terminate external review, the IRO will, within one (1) business day of making its decision, notify the claimant, the claims administrator, and the Plan. Upon receipt of any information submitted by the claimant, the IRO must forward that information to the claims administrator within one (1) business day. The claims administrator may then reconsider the adverse benefit determination. If the claims administrator decides to reverse the adverse benefit determination, the claims administrator must provide written notice of its decision to the claimant and the IRO within one (1) business day after making the decision. The IRO will then terminate the external review.

IRO DECISION:
The IRO will review all of the information and documents received. In reaching a decision, the IRO will review the claim and not be bound by any decisions or conclusions reached during the claims administrator's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's medical records
- The attending health care professional's recommendation
- Reports from appropriate health care professionals and other documents submitted by the Plan, the claimant, or the treating provider.
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law

- The opinion of the IRO's clinical reviewer(s) after considering the information described above, to the extent the information or documents are available and the clinical reviewer(s) considers it appropriate.

The IRO will provide written notice of its Final External Review Decision within 45 days after receiving the Request for External Review form. The IRO will deliver its Final External Review Decision to the claimant, the claims administrator, and the Plan. The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (e.g., the date or dates of service, the health care provider, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials)
- The date the IRO received the external review assignment from the claims administrator and the date of the IRO's decision.
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, that the IRO considered in making its determination.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision.

- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law to either the Plan or the claimant.
- A statement that the claimant may still be eligible to seek judicial review of any adverse external review determination.
- Current contact information, including the telephone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the claimant.

If the IRO's Final External Review Decision reverses the claims administrator's or Appeals Committee's adverse benefit determination, the Plan must immediately provide the health benefit (including immediately authorizing or immediately paying benefit) for the claim.

EXPEDITED EXTERNAL REVIEW PROCESS:
The claimant may request an expedited external review at the time he/she receives:

- An initial determination as stated in an Explanation of Benefits ("EOB") involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or would jeopardize his/her ability to regain maximum function and he/she has filed a request for an expedited internal appeal.
- An adverse benefit determination on appeal, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize his/her life or health or would jeopardize his/her ability to regain maximum function, or if the appeal determination concerns an admission, availability of care, continued stay, or health care item or service for which he/she received emergency services, but has not been discharged from a facility

Preliminary Review: Immediately upon receipt of the request for expedited external review, the claims administrator will conduct the preliminary review described above for standard external review. The claims administrator will immediately send the claimant a notice of its determination.

Referral to IRO for Expedited Review: If the claims administrator determines that the request for expedited external review is eligible for expedited external review, the claims administrator will assign an IRO. The claims administrator will provide or transmit all necessary documents and information considered in making its initial determination or the adverse benefit determination to the IRO electronically, by telephone, by fax, or by any other available expeditious method. The IRO will review the information and documents described above for standard external review and will provide a decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO will provide written confirmation of the decision to the claimant, the claims administrator, and the Plan.

If the IRO's decision reverses the claims administrator's or Appeals Committee's determination, the Plan must immediately provide the health benefit (including immediately authorizing or immediately paying benefits) for the claim.

IRO RECORDS:
After its Final External Review Decision, the IRO will maintain records of all claims and notices associated with the external review process for six (6) years. An IRO will make such records available for examination by the claimant, the Plan, or the state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

CONTINUATION OF COVERAGE (FEDERAL LAW – COBRA) ACTIVE EMPLOYEES

A federal law, the *Consolidated Omnibus Budget Reconciliation Act of 1985,* as amended ("COBRA"), offers participants the opportunity to continue health coverage under the Plan in certain circumstances.

COBRA continuation coverage is a temporary continuation of health coverage when it otherwise would end because of a "qualifying event." After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your spouse, and any dependent children could become qualified beneficiaries if you have coverage under the Plan on the day before a qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

Please Note: You may have other options available to you when you lose Plan coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

QUALIFIED BENEFICIARIES AND QUALIFYING EVENTS COVERED EMPLOYEE:
You are eligible for COBRA continuation coverage if you lose coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.

SPOUSE OF COVERED EMPLOYEE:
Your spouse is eligible for COBRA continuation coverage if he/she loses coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.
- You die.
- You become divorced or legally separated from your spouse.
- You enroll in Medicare benefits (under Part A, Part B or both)

DEPENDENT CHILDREN:
Your dependent children are eligible for COBRA continuation if they lose coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.
- You die.
- You become divorced or legally separated from your spouse.
- Your child loses eligibility for coverage as a "dependent child" under the Plan.

- You enroll in Medicare benefits (under Part A, Part B or both) Notification of Qualifying Events.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of your employment, the reduction in your work hours, your enrollment in Medicare, or your death, the Employer will notify the Plan Administrator of the qualifying event.

For other qualifying events (divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

HOW COBRA CONTINUATION COVERAGE IS OFFERED
After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment notice by mail within 14 business days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that anyone who may become a qualified beneficiary maintain a current address with the Plan Administrator to ensure that he/she receives a COBRA enrollment notice following a qualifying event. Qualified beneficiaries have 60 calendar days from the date coverage ends due to a qualifying event or from the date of the COBRA notice, whichever is later, to elect COBRA continuation coverage. If the qualified beneficiary fails to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

EFFECTIVE DATE OF COBRA CONTINUATION COVERAGE
If elected within the period allowed for the election, COBRA continuation coverage is effective retroactively to the date health coverage would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for COBRA continuation coverage in this retroactive period. However, if the qualified beneficiary waives COBRA continuation coverage and then revokes the waiver within the 60-day election period, the elected COBRA continuation coverage begins on the date the waiver is revoked.

HOW LONG COBRA CONTINUATION COVERAGE LASTS
COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child COBRA continuation coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of work hours. This 18-month period of COBRA continuation coverage can be extended in two ways:

Disability Extension of 18-Month Period of COBRA Continuation Coverage:
If a qualified beneficiary in your family is determined by the Social Security Administration to be disabled, and you notify the Plan Administrator in a timely fashion, you and all qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, if all of the following conditions are met:

- The COBRA qualifying event was your termination of employment or reduction in work hours.
- The qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 calendar days of COBRA continuation coverage, and the disability lasts at least until the end of the 18-month period of COBRA continuation coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the Plan Administrator within 60 calendar days of receipt of the notice and before the end of the initial 18 months of COBRA continuation coverage.
- An increased premium of 150 percent of the monthly cost of coverage is paid, beginning with the 19th month of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage:
If another qualifying event occurs during the first 18 months of COBRA continuation coverage, your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator.

This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, get divorced or legally separated, or a dependent child is no longer eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Medicare Extension for Dependents
If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for 18 months from the date of termination of employment or reduction in work hours.

What COBRA Continuation Coverage Costs
COBRA participants must pay monthly premiums for coverage. Premiums are based on the full cost per covered person set at the beginning of the plan year, plus 2 percent for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

An increased premium of 150 percent of the cost of coverage must be paid in the case of disability, beginning with the 19th month of COBRA continuation coverage.

Payment is due at enrollment, but there is a 45-day grace period from the date the qualified beneficiary mails the enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s). Note that COBRA continuation coverage will not be effective until the qualified beneficiary actually pays the COBRA premium; if payment is not made with the enrollment, COBRA continuation coverage will be retroactively activated back to the date of the enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

General Provisions
If you, your spouse, and/or dependent child(ren) elect COBRA continuation coverage:

- You can keep the same level of coverage you had as an active participant or choose a lower level of coverage.
- Coverage is effective as of the date of the qualifying event. However, if you waive COBRA continuation coverage and then revoke the waiver within the 60-day election period, the elected coverage begins on the date the waiver is revoked.
- You or your dependent may change coverage:
  - During the annual open enrollment period
  - If you have a Life Status Change
  - If you have a change in circumstance recognized by the Internal Revenue Service (“IRS”)
- You may enroll any newly-eligible spouse or child under Plan rules.

When COBRA Continuation Coverage Ends
COBRA continuation coverage ends when the first of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period. Coverage for a newly-acquired dependent who has been added for the balance of a continuation period would end at the same time that your continuation period ends.
- The qualified beneficiary becomes covered under another medical plan not offered by the Employer.
- The qualified beneficiary fails to make participant contributions by the due date as required.
- The Employer stops providing any health benefits to any employee.
- The qualified beneficiary becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payor Rules or other federal law.

- The qualified beneficiary dies.
- Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation coverage (such as fraud)
- The Social Security Administration determines that the qualified beneficiary is no longer disabled (if entitled to 29 months of COBRA continuation coverage under the special disability rule), in which case the extended portion of the COBRA continuation coverage will end with the month that begins more than 30 days after the Social Security Administration's determination.

TRADE ACT

Federal law provides for a tax credit for certain individuals who become eligible for Trade Adjustment Assistance ("TAA") benefits, particularly in the event of terminations of employment that are related to international trade, and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC"). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment for a portion of the premiums paid for qualified health coverage, including COBRA continuation coverage.

In addition, if you initially decline COBRA continuation coverage and, within 60 days after your loss of qualified health coverage under the Plan, you are deemed eligible, by the U.S. Department of Labor or a state labor agency, for TAA benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA benefits-eligible if the election is made within six (6) months after the date of the TAA-related loss of qualified health coverage. If you elect COBRA continuation coverage during this special election period, COBRA continuation coverage will be effective on the first day of the special election period and end on the same day that it would have ended if COBRA continuation coverage had been elected during the regular election period available as a result of your trade-related termination of employment or reduction in work hours (generally, 18 months, unless you experience one of the events discussed under "When COBRA Continuation Coverage Ends" above).

If you receive a determination that you are TAA benefits-eligible, you must notify the Plan Administrator immediately. More information about these TAA provisions is available at doleta.gov/tradeact.

CONTINUATION OF COVERAGE (FEDERAL LAW—COBRA) RETIREES

The COBRA information in this section applies when a retiree's health coverage or the health coverage of a retiree's dependent under the Plan is ended.

QUALIFIED BENEFICIARIES AND QUALIFIED EVENTS

Covered Retiree:
You are eligible for COBRA continuation coverage if you lose your health coverage under the Plan because the Employer commences Chapter 11bankruptcy proceedings.

Spouse of Covered Retiree:
Your spouse is eligible for COBRA continuation coverage if he/she loses health coverage under the Plan because of one of the following qualifying events:

- You die.
- You become divorced or legally separated from your spouse.
- The Employer commences Chapter 11 bankruptcy proceedings.

Dependent Children:
Your dependent children are eligible for COBRA continuation if they lose health coverage under the Plan because of one of the following qualifying events:

- You die.
- You become divorced or legally separated from your spouse.
- Your child loses eligibility for coverage as a "dependent child" under the Plan.
- The Employer commences Chapter 11 bankruptcy proceedings.

NOTIFICATION OF QUALIFYING EVENTS

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the Employer's Chapter 11 bankruptcy proceedings, the Employer will notify the Plan Administrator of the qualifying event. For other qualifying events, you or the qualified beneficiary must notify the Plan Administrator within 60 days after the later of the date the qualifying event occurs or the day the qualified beneficiary loses coverage because of the qualifying event. If you or the qualified beneficiary fails to notify the Plan Administrator within this 60-day period, the dependent will not be entitled to elect COBRA continuation coverage. In addition, if any benefit claims are mistakenly paid for expenses incurred after the date health benefit coverage under the Plan would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any payments mistakenly made.

HOW COBRA CONTINUATION COVERAGE IS OFFERED

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage is offered to each qualified beneficiary.

The Plan Administrator provides a COBRA enrollment notice by mail within 14 days after receiving notice of the qualifying event, and each qualified beneficiary has an independent right to elect COBRA continuation coverage.

You may elect COBRA continuation coverage on behalf of your spouse, and parents may elect COBRA continuation coverage on behalf of their children. It is critical that anyone who may become a qualified beneficiary maintain a current address with the Plan Administrator to ensure that he/she receives a COBRA enrollment notice following a qualifying event.

Qualified beneficiaries have 60 days from the date coverage ends due to a qualifying event or from the date of the COBRA notice, whichever is later, to elect COBRA continuation coverage. If the qualified beneficiary fails to elect COBRA continuation coverage within the applicable timeframe, the opportunity to continue coverage under COBRA will be forfeited.

EFFECTIVE DATE OF COBRA CONTINUATION COVERAGE

If elected within the period allowed for the election, COBRA continuation coverage is effective retroactively to the date health coverage would otherwise have terminated due to the qualifying event, and the qualified beneficiary will be charged for COBRA continuation coverage in this retroactive period. However, if the qualified beneficiary waives COBRA continuation coverage and then revokes the waiver within the 60-day election period, the elected COBRA continuation coverage begins on the date the waiver is revoked.

HOW LONG COBRA CONTINUATION COVERAGE LASTS

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child.

In the case of a bankruptcy proceeding, COBRA continuation coverage generally lasts for you until the date of your death. For your spouse or dependent child(ren), COBRA continuation coverage ends on the earlier of:

- The date of your spouse’s or dependent child’s death
- 36 months after the date of your death

WHAT COBRA CONTINUATION COVERAGE COSTS

COBRA participants must pay monthly premiums for coverage. Premiums are based on the full cost per covered person set at the beginning of the plan year, plus 2 percent for administrative costs. Dependents making separate elections are charged the same rate as a single retiree.

Payment is due at enrollment, but there is a 45-day grace period from the date the qualified beneficiary mails the enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s). Note that COBRA continuation coverage will not be effective until the qualified beneficiary actually pays the COBRA premium; if payment is not made with the enrollment, COBRA continuation coverage will be retroactively activated back to the date of the enrollment upon receipt of payment.

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

GENERAL PROVISIONS

If you, your spouse, and/or dependent child(ren) elect COBRA continuation coverage:

- You can keep the same level of coverage you had as a covered retiree or choose a lower level of coverage.
- You may change coverage during the annual open enrollment period or if you have a Life Status Change.
- You may enroll any newly-eligible dependent under Plan rules.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage ends when one of the following events occurs:

- The qualified beneficiary reaches the maximum COBRA continuation period.
- The qualified beneficiary becomes covered under another medical plan not offered by the Employer.
- The qualified beneficiary fails to make participant contributions by the due date as required.
- The Employer stops providing any retiree medical benefits to any retiree.
- The qualified beneficiary dies.
- Any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (such as fraud).

PLAN'S PRIVACY PRACTICES

This section explains how medical information about you may be used or disclosed, and how you can get access to this information. Please review this section carefully.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The following is a list of the ways that the Plan may use and disclose health information about you. For each category of permitted use and disclosure, an explanation and some examples are provided. Not every possible use or disclosure is listed, but any permitted use or disclosure will fall into one of these categories:

Payment Functions:

The Plan may use or disclose health information about you to determine eligibility for Plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine Plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under the Plan.

Health Care Operations:

The Plan may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to Plan coverage, conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management, and general administration.

Required by Law:

As required by law, the Plan may use and disclose your health information. For example, the Plan may disclose medical information when required by discovery, subpoena, or court order in a litigation proceeding which you or another person has commenced.

Public Health:

As required by law, the Plan may disclose your health information to public health authorities for purposes related to preventing and controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the U.S. Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Health Oversight Activities:

The Plan may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

Judicial and Administrative Proceedings:

The Plan may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement:
The Plan may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a subpoena or court order, or for other law enforcement purposes.

Coroners, Medical Examiners, and Funeral Directors:
The Plan may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

Organ and Tissue Donation:
The Plan may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

Public Safety:
The Plan may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

National Security:
The Plan may disclose your health information for military, national security, prisoner, and government benefits purposes.

Workers' Compensation:
The Plan may disclose your health information as necessary to comply with workers' compensation or similar laws.

Marketing:
The Plan may contact you to give you information about health-related benefits and services that may be of interest to you.

Disclosures to Plan Sponsors:
The Plan may disclose your health information to the Sponsor of the Plan, for purposes of administering benefits under the Plan.

When the Plan May Not Use or Disclose Your Health Information
Except as described in the Notice of Privacy Practices, the Plan will not use or disclose your health information without written authorization from you. If you do authorize the Plan to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, the Plan will no longer be able to use or disclose health information about you for the reasons covered by the written authorization, though the Plan will be unable to take back any disclosures already made with your permission.

STATEMENT OF YOUR HEALTH INFORMATION RIGHTS

Right to Request Restrictions:
You have the right to request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to the restrictions that you request. To request restrictions, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Request Confidential Communications:
You have the right to receive your health information through a reasonable alternative means or at an alternative location. To request confidential communications, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Inspect and Copy:
You have the right to inspect and copy your health information that may be used to make decisions about your Plan benefits. To inspect and copy such information, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Request Amendment:
You have the right to request that the Plan amend your health information that you believe is incorrect or incomplete. The Plan is not required to change your health information and, if the request is denied, the Plan will provide you with information about the denial and how you can disagree with the denial. To request an amendment, you must submit the request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

Right to Accounting of Disclosures:
You have the right to receive a list or “accounting of disclosures” of your health information made by the Plan, except that the Plan does not have to account for disclosures made for purposes of payment functions or health care operations, or made to you. To request this accounting of disclosures, you must submit a request in writing to the Manager, Employee/Retiree Benefits, Gwinnett County Department of Human Resources, 75 Langley Drive, Lawrenceville, GA 30046

INFORMATION AND COMPLAINTS

For more information regarding these rights and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available from the Plan Administrator.

Complaints about how the Plan handles your health information should be directed to Director, Department of Human Resources, Gwinnett County, 75 Langley Drive, Lawrenceville, GA 30046, who has been designated as the Privacy Officer for the Plan. The Plan will not retaliate against you in any way for filing a complaint. All complaints to the Plan must be submitted in writing. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

ADMINISTRATIVE INFORMATION

PLAN NAME
The official name of the Plan is the Gwinnett County Health Benefit Plan.

PLAN EMPLOYER/PLAN SPONSOR
The Employer/Sponsor for the Plan is:
Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville, GA 30046

PLAN ADMINISTRATOR
The Plan Administrator for the Plan is:
Gwinnett County Board of Commissioners
Department of Human Resources
75 Langley Drive
Lawrenceville, GA 30046
Telephone: 770.822.7915

ADMINISTRATION INFORMATION
This section contains important information about how your benefits are administered.

AGENT FOR SERVICE OF LEGAL PROCESS
The agent for service of legal process under the Plan is:
Gwinnett County Board of Commissioners
75 Langley Drive
Lawrenceville, GA 30046
Attn: Director, Human Resources Department

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

PLAN YEAR
The plan year is a calendar year, which runs from January 1 to December 31.

CLAIMS ADMINISTRATORS AND AUTHORITY TO REVIEW CLAIMS
Your eligibility for health benefits is determined by the Plan. The Plan Administrator has full discretionary authority to interpret the terms of the Plan summarized in this SPD and determine your eligibility and benefit claims under the Plan's terms. In some cases, the Plan Administrator has delegated this authority.

The Plan Administrator has delegated its authority to determine benefit claims to the claims administrators listed above. Health benefits under the Plan are paid only if the claims administrator decides, in their discretion, that the claimant is entitled to them. The claims administrator has:

- The authority to make final determinations regarding benefit claims under the Plan.

- The discretionary authority to:
  - Interpret the Plan based on provisions and applicable law and make factual determinations about claims arising under the Plan.
  - Decide the amount, form, and timing of benefits.
  - Resolve any other matter under the Plan that is raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the claims administrator's decision is final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the claims administrator's decision was an abuse of administrator discretion.

EMPLOYER'S RIGHT TO USE YOUR SOCIAL SECURITY NUMBER FOR ADMINISTRATION OF BENEFITS

The Employer has the right to use your Social Security number for benefit administration purposes, including tax reporting.

UNCLAIMED FUNDS

The applicable incorporated document will govern the handling of any unclaimed funds under the Plan.

NON-ASSIGNMENT OF BENEFITS

You cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit payment. However, benefits will be provided to your child if required by a Medical Child Support Order or a National Medical Support Notice. In addition, subject to your written direction, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless you request otherwise in writing, be paid directly to the person rendering a service to you. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

This Summary Plan Description contains a summary in English of your plan rights and benefits under the Gwinnett County Group Health Insurance Plan. If you have difficulty understanding any part of this Summary Plan Description, contact the Plan Administrator at 770.822.7915.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024-12/31/2024

aetna™

GWINNETT COUNTY BOARD OF COMMISSIONERS :
Aetna Choice® POS II - Bronze

Coverage for: EE Only; EE+ Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only $3,900; EE+ Family: Individual $3,900/ Family $7,800. Out-of-Network: EE Only $7,800; EE+ Family: Individual $15,600/ Family $15,600.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The family deductible is cumulative for all family members. **In Network:** The family deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual deductible. **Out of Network:** The family deductible must be met by one family member or a combination of family members before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $6,900; EE+ Family: Individual $6,900/ Family $13,800. Out-of-Network: EE Only $13,800; EE+ Family: Individual $27,600/ Family $27,600.	The out–of–pocket limit is the most you could pay in a year for covered services before the plan begins to pay 100%. The family out-of-pocket limit is cumulative for all family members. **In Network**: The family out-of-pocket limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual out-of-pocket limit. **Out of Network**: The overall family out-of-pocket limit can be met by one family member or a combination of family members.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You pay more if you use an out-of-network provider, and you may receive a bill for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance, except no charge for immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency transport: not covered, unless pre-authorized.
	Urgent care	30% coinsurance	50% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 30% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	30% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & habilitation services.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? .

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace**.**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,900**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,900
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,260**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,900**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,900
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,900**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᎦᏬᏂᎯᏍᏗ ᏗᏂᏍᎦᏢᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᏫᏏᎳᏉᎥᎦ 1-800-370-4526 ᏅᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᏢᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-800-370-4526 လၢတအိဉ်ဒီးတက်လၢာ်ဘျုာ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - [illegible] 1-800-370-4526 [illegible].

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں-

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024-12/31/2024

aetna™

GWINNETT COUNTY BOARD OF COMMISSIONERS :
Aetna Choice® POS II - Gold

Coverage for: EE Only; EE+ Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only $1,600; EE+ Family $3,200. Out-of-Network: EE Only $3,200; EE+ Family $6,400.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The family deductible is a cumulative deductible for all family members. The overall family deductible must be met by one family member or a combination of family members before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $2,800; EE+ Family $5,600. Out-of-Network: EE Only $5,600; EE+ Family $11,200.	The out–of–pocket limit is the most you could pay in a year for covered services. The family out-of-pocket limit is a cumulative out-of-pocket limit for all family members. The overall family out-of-pocket limit must be met by one family member or a combination of family members before the plan begins to pay 100%.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You pay more if you use an out-of-network provider, and you may receive a bill for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	50% coinsurance	None
	Specialist visit	15% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance, except no charge for immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	Coinsurance/prescription: 15% (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Coinsurance/prescription: 15% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Coinsurance/prescription: 15% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	50% coinsurance	None
	Physician/surgeon fees	15% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Non-emergency transport: not covered, unless pre-authorized.
	Urgent care	15% coinsurance	50% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	15% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 15% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	15% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	15% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	15% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & habilitation services.
	Habilitation services	15% coinsurance	50% coinsurance	
	Skilled nursing care	15% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	15% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	15% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing	• Routine eye care (Adult & Child) • Routine foot care • Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture - 30 visits/calendar year. • Bariatric surgery	• Chiropractic care - 30 visits/calendar year. • Hearing aids - 1 hearing aid per ear/36 months.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,550**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,550**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,170**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,550**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,550
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏲᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏏᎳᏮᎥᏕ 1-800-370-4526 ᎤᎾᎢ Ꮭ ᎠᎱᏍᏗ ᏧᎬᏩᎵᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-800-370-4526 လၢတအိဉ်ဒီးတက်လၢာ်ဘျုာ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-370-4526

Russian - Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.

Samoan - Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.

Serbo-Croatian - Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.

Spanish - Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.

Sudanic-Fulfude - Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.

Swahili - Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.

Syriac - ܐܢ ܐܢܬ ܐܢܬ ܡܡܠܠܢܐ ܐܬܘܪܝܐ ܥܗܕܢܘܬܐ ܕܠܫܢܐ ܐܝܬ ܠܟ ܒܡܓܢܐ ܩܪܝ ܠ 1-800-370-4526 ܒܡܓܢܐ.

Tagalog - Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.

Telugu - భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)

Thai - สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย

Tongan - Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ōtōngi.

Trukese - Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.

Turkish - (Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.

Ukrainian - Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.

Urdu - بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں۔

Vietnamese - Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.

Yiddish - פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.

Yoruba - Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.

aetna™

GWINNETT COUNTY BOARD OF COMMISSIONERS :
Aetna Choice® POS II - Silver

Coverage for: EE Only; EE+ Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only $2,350; EE+ Family $4,700. Out-of-Network: EE Only $4,700; EE+ Family $9,400.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The family deductible is a cumulative deductible for all family members. The overall family deductible must be met by one family member or a combination of family members before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $4,900; EE+ Family: Individual $6,900/ Family $9,800. Out-of-Network: EE Only $9,800; EE+ Family: Individual $19,600/ Family $19,600.	The out–of–pocket limit is the most you could pay in a year for covered services before the plan begins to pay 100%. The family out-of-pocket limit is cumulative for all family members. **In Network**: The family out-of-pocket limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual out-of-pocket limit. **Out of Network**: The overall family out-of-pocket limit can be met by one family member or a combination of family members.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You pay more if you use an out-of-network provider, and you may receive a bill for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance, except no charge for immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	Covers 30-day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Coinsurance/prescription: 30% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency transport: not covered, unless pre-authorized.
	Urgent care	30% coinsurance	50% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 30% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	30% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & habilitation services.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,350**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,350
Copayments	$0
Coinsurance	$2,550
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,350**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,350
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,270**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,350**
Specialist coinsurance	**30%**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,350
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,450**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	1-800-370-4526 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ᎾᏍᏉᎩᎾ ᏚᏳᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏓᎳᏛᎥᏍ 1-800-370-4526 ᏅᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-800-370-4526 လၢတအိဉ်ဒီးတက်လၢာ်ဘျုာ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-370-4526

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac -	[illegible] 1-800-370-4526 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ʻoku fiema'u hā tokoni ʻi he lea faka-Tonga telefoni 1-800-370-4526 ʻo ʻikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں-
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ̀wọ́ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024-12/31/2024

aetna™

GWINNETT COUNTY BOARD OF COMMISSIONERS :
Aetna Choice® POS II - Traditional

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only $1,600; EE+ Family: Individual $1,600/ Family $3,200. Out-of-Network: EE Only $3,200; EE+ Family: Individual $3,200/ Family $6,400.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The family deductible is cumulative for all family members. The family deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual deductible.
Are there services covered before you meet your deductible?	Yes. In-network office visits, prescription drugs & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EE Only $4,200; EE+ Family: Individual $4,200/ Family $8,400. Out-of-Network: EE Only $8,400; EE+ Family: Individual $8,400/ Family $16,800.	The out–of–pocket limit is the most you could pay in a year for covered services before the plan begins to pay 100%. The family out-of-pocket limit is cumulative for all family members. The family out-of-pocket limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You pay less if you use a provider in the plan's network. You pay more if you use an out-of-network provider, and you may receive a bill for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$75 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance, except no charge for immunizations	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	Copay/prescription, deductible doesn't apply: $20 for 30 day supply (retail & EDS Network), $40 for 31-90 day supply (EDS Network & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/advancedcontrol	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $50 for 30 day supply (retail & EDS Network), $100 for 31-90 day supply (EDS Network & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $75 for 30 day supply (retail & EDS Network), $150 for 31-90 day supply (EDS Network & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	No coverage for non-emergency use.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Non-emergency transport: not covered, unless pre-authorized.
	Urgent care	$75 copay/visit, deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $75 copay/visit, deductible doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$75 copay/visit, deductible doesn't apply	50% coinsurance	60 visits/calendar year for Physical, Occupational & Speech Therapy combined, including outpatient hospital services. Includes treatment of Autism & habilitation services.
	Habilitation services	$75 copay/visit, deductible doesn't apply	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	30% coinsurance	50% coinsurance	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture - 30 visits/calendar year.
- Bariatric surgery
- Chiropractic care - 30 visits/calendar year.
- Hearing aids - 1 hearing aid per ear/36 months.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,600**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,260**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,600**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,600**
Specialist copayment	**$0**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

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

Non-Discrimination

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-370-4526 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-370-4526 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-800-370-4526
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-370-4526-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏬᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᏓᎢ (ᏣᎳᎩ) ᏫᏏᎳᏛᎥᏍ 1-800-370-4526 ᎤᎾᎢ ᏝᎪᎱᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-370-4526.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526.
French -	Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526.
Japanese -	日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢးတက်ကတိၤကျိာ်အဂီၢ် ကျိာ် 1-800-370-4526 လၢတအိဉ်ဒီးတက်လၢာ်ဘျုာ်လၢာ်စုဟဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ́ɔ̀-wùdùǔn wɛ̃ɛ, dá 1-800-370-4526
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-370-4526 ໂດຍບໍ່ເສຍຄ່າໃຫ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-370-4526
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-370-4526 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-370-4526

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-370-4526 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo.
Syriac -	[illegible] 1-800-370-4526 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-370-4526 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526.
Urdu -	بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 1-800-370-4526 . پر بات کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-370-4526 פריי פון אפצאל.
Yoruba -	Fún ìrànlọ́wọ́ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá.

Choice POS II medical plan

Booklet

Prepared for:

Employer:	Gwinnett County Board of Commissioners
Contract number:	MSA-0737528
Plan name:	Aetna Choice POSII
Booklet:	1
Plan effective date:	January 1, 2023
Plan issue date:	March 17, 2023

Third Party Administrative Services provided by
Aetna Life Insurance Company

Table of contents

Welcome

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

Welcome to Aetna.

Introduction

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

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

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

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

How we use words

When we use:

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

Contact us

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

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

- Calling your **Aetna** Concierge at the toll-free number 1-866-307-6077 on your ID card from 8:00 a.m. to 6:00 p.m. Monday through Friday Visiting https://www.aetna.com to access your member website
- Writing us at 151 Farmington Ave, Hartford, CT 06156

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

Your ID card

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

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service providers". These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but, we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Coverage and exclusions

Providing covered services

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

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

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the network pharmacy when you get a **prescription** filled

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

For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is never covered. This is an exclusion.
- Home health care is generally covered but it is a **covered service** only up to a set number of visits a year. This is a limitation.
- Your **provider** may recommend services that are considered **experimental or investigational** services. But an **experimental or investigational** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

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

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

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

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

Emergency Ground Ambulance

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency Ground Ambulance

Covered services also include precertified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

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

Applied behavior analysis

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

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

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

Autism spectrum disorder

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

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

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

Behavioral health

Mental health treatment

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

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

Substance related disorders treatment

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

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

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

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

Clinical trials

Routine patient costs

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

The following are not **covered services**:

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

Experimental or investigational therapies

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

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

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

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

Durable medical equipment (DME)

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

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home

- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

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

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

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

The following are not **covered services**:
- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

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

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

Your coverage for **emergency services** will continue until the following conditions are met:
- You are evaluated and your condition is stabilized and
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

If both of the above conditions are met and you continue to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician** (**PCP**).

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

Habilitation therapy services

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

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

Outpatient physical, occupational, and speech therapy

Covered services include:

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

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

The following are not **covered services**:

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

Hearing aids

Hearing aid means:

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

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

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

The following are not **covered services**:

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

Hearing exams

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

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Home health care

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

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

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous **skilled nursing services**. See the schedule of benefits for more information on the intermittent requirement.

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

The following are not **covered services**:

- Any type of care that does not require the skills of a health professional
- 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

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

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

- Bereavement counseling
- Respite care

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

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

The following are not **covered services**:

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

Hospital care

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

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood derivatives, but not the expense of the blood or blood product

The following are not **covered services**:

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

Infertility services

Basic infertility

Covered services include seeing a **provider:**

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

The following are not **covered services**:

- All **infertility** services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Intrauterine/intracervical insemination services.

Jaw joint disorder treatment

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

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

The following are not **covered services**:

- Non-surgical medical and dental services, and therapeutic services related to **jaw joint disorder**

Maternity and related newborn care

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

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

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

The following are not **covered services**:

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

Obesity surgery and services

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

Covered services include:

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

The following are not **covered services:**

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the booklet.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications

- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- Cutting out:
  - Teeth partly or completely impacted in the bone of the jaw
  - Teeth that will not erupt through the gum
  - Other teeth that cannot be removed without cutting into bone
  - The roots of a tooth without removing the entire tooth
  - Cysts, tumors, or other diseased tissues.
- Cutting into gums and tissues of the mouth
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

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

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

The following are not **covered services**:

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

Physician services

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

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

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

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

Pregnancy Termination

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

- Abortion, where permitted by state and local laws.

Prescription drugs - outpatient

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

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

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

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the **formulary exclusions list** unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See *the Requesting a medical exception* section or just contact us.

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

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

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

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

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

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 30 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Prescription refills after the first fill can be filled at a network **mail order pharmacy**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

All **specialty prescription drug** fills after the first fill must be filled at a network **specialty pharmacy** unless it is an urgent situation.

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

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy

- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

When the pharmacy you use leaves the network

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

How to get an emergency prescription filled

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

Type of pharmacy	Your cost share is
A network pharmacy	The plan cost share
An out-of-network pharmacy	The full cost of the **prescription**

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

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

Other covered services

Contraceptives (birth control)

For females who are able to become pregnant, **covered services** include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

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

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

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine
- Blood glucose meters and insulin pumps

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

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

Infertility drugs
Covered services include synthetic ovulation stimulant **prescription** drugs used to treat the underlying medical cause of **infertility**.

Obesity drugs
Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

You must be diagnosed by your **provider**, including a physical exam and outpatient diagnostic lab work, with one of the medical conditions listed here:

- Morbid obesity
- Obesity with one or more of the following obesity-related risk factors:
  - Coronary artery disease
  - Dyslipidemia (LDL and HDL cholesterol, triglycerides)
  - Hypertension
  - Obstructive sleep apnea
  - Type 2 diabetes mellitus

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

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

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

The following are not **covered services**:

- Abortion drugs (except for abortion drugs dispensed by a **provider**, including a **telemedicine provider**)
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception

  - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used 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 alter the shape or appearance of a sex organ unless listed as a **covered service**
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies

- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the booklet

- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the booklet

- **Infertility**:
  - Injectable **prescription** drugs used primarily for the treatment of **infertility**
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card

- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF

- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**
  - Plan shall exclude from coverage certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs). Plan's designee, **Aetna**, shall determine which drugs meet the criteria for exclusion.

Preventive care

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

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

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

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

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

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

Breast-feeding support and counseling services

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

Breast pump, accessories and supplies

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

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

Counseling services

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

- Alcohol or drug misuse

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

Family planning services – female contraceptives

Covered services include family planning services as follows:

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

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

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **health professional**

Immunizations

Covered services include preventive immunizations for infectious diseases.

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

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

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening
- Maternal weight

- Rh incompatibility screening

Routine cancer screenings

Covered services include the following routine cancer screenings:

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

Routine physical exams

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

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

Covered services include:

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

Well woman preventive visits

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

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

Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

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

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies

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

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

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

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

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

Pulmonary rehabilitation

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

Short-term rehabilitation services

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

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

Covered services include:

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

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language

- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include **precertified** inpatient **skilled nursing facility** care. This includes:

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

Telemedicine

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

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

The following are not **covered services**:

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

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

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

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

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

Diagnostic x-ray and other radiological services

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

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

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

cancer diagnosis during a **hospital stay**.

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

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

Key Terms

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

Gene

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

Molecular

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

Therapeutic

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

GCIT **covered services** include:

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

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

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

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

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

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

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

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

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

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

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

This includes the following transplant types:

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

Covered services also include:

- Travel and lodging expenses

- If you are working with an IOE facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility
- Coach class air fare, train or bus travel are examples of **covered services**

Network of transplant facilities

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

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this booklet and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket**, and limits, unless stated differently in this booklet and schedule of benefits

Important note:
If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

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

The following are not **covered services**:

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

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

Covered services include services and supplies to treat an urgent condition as described below:

- Urgent condition within the network (in-network)
  - If you need care for an urgent condition, you should first seek care through your **physician**, **PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center that is in-network.
- Urgent condition outside the network (out-of-network)
  - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and the service can't be delayed.

If you go to an urgent care center for what is not an urgent condition, the plan may not cover your expenses. See the schedule of benefits for more information.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Walk-in clinic

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

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

General plan exclusions

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

Behavioral health treatment

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

- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- 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
- Sexual deviations and disorders except as described in the *Coverage and exclusions* section
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section

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

Examples of these are:

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

Cosmetic services and plastic surgery

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

Cost share waived

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

Court-ordered services and supplies

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

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or changing containers and clamping tubing
- Watching or protecting you

- Respite care, adult or child day care, or convalescent care
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
- Dental implants

Educational services

Examples of these are:

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Foot care

Routine services and supplies for the following:

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

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes

Gender Affirming Treatment

- Any treatment, drug, or service 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

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

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

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

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

Growth/height care

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

Jaw joint disorder treatment

Surgical and non-surgical medical, dental, diagnostic or therapeutic services related to **jaw joint disorder**

Maintenance care

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

Medical supplies – outpatient disposable

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

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

Missed appointments

Any cost resulting from a canceled or missed appointment

Nutritional support

Any food item, including:

- Infant formulas

- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

Other non-covered services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Prescription or non-prescription drugs and medicines – outpatient

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

Private duty nursing

Routine exams and preventive services and supplies

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

Services not permitted under applicable state or local laws

Some state or local laws restrict the scope of health care services that a **provider** may render. In such cases, the plan will not cover such health care services.

Services provided by a family member

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

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.

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery**, **prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the *Covered services and exclusions* section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services and exclusions* section
- Nicotine patches
- Gum

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

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

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

Providers

Our **provider network** is there to give you the care you need. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also contact us to ask for a copy of the directory. We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location or their provider group is in the network. See the Contact us section for more information.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**. Your plan may pay a bigger share for **covered services** 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.

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

With your out-of-network coverage:

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

Who provides the care

Network providers

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

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

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

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

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

Your PCP

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

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

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

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

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

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

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

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

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

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

If this situation applies to you, contact us for details. If we approve your request to keep going to your current **provider**, we will tell you how long you can continue to see the **provider**. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

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

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

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

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

Precertification

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

In-network

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

Out-of-network

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

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

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

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

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

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

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

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

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

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

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

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

Outpatient –

- Applied behavior analysis
- ART services
- Complex imaging
- Comprehensive **infertility** services
- Cosmetic and reconstructive **surgery**
- Gene-based, cellular and other innovative therapies (GCIT)
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Outpatient back **surgery** not performed in a **physician's** office
- Partial hospitalization treatment – **mental health disorders** and **substance related disorders** treatment
- Sleep studies
- Transcranial magnetic stimulation (TMS)
- Wrist **surgery**

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

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

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

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

- Call the toll-free number on your ID card
- Log in to the Aetna website at https://www.aetna.com/
- Submitting the request in writing to CVS Health ATTN: Aetna PA, 1300 E Campbell Road, Richardson, TX 75081

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

What the plan pays and what you pay

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

The general rule

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

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

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

Negotiated charge

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

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

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

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

Some of these arrangements are called:

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

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

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

Recognized charge

Voluntary Services

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

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

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

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

Service or Supply	**Out-of-Network Plan Rate**
Professional services*	100% of the Medicare allowed rate
Inpatient and outpatient charges of **hospitals***	100% of the Medicare allowed rate
Inpatient and outpatient charges of facilities other than **hospitals***	
Prescription drugs	110% of the average wholesale price (AWP)

**Involuntary services are not paid as outlined above. See Involuntary Services and Surprise Bills for information on how these claims are paid under the plan.*

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 Patient Advocacy Services are available for your claim, additional information will be provided to you.

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

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

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- 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.

- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other **providers** charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
  - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
  - Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
  - For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
  - For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
  - For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
  - For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

When the **recognized charge** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

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

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

We base our reimbursement policies on our review of:

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

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

Get the most from your benefits:
We have online tools to help you decide whether to get care and if so, where. Use the 'Estimate the Cost of Care' tool or 'Payment Estimator' tool on the Aetna website. The website may contain additional information that can help you determine the cost of a service or supply.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services or do not consent to receive services from an **out-of-network provider**, even where you try to stay in the network for your **covered services**. You may then get a bill at a rate that you didn't expect. This is called a surprise bill. A federal law called the No Surprises Act protects you from surprise bills by limiting cost sharing and prohibiting balance billing by out of network providers.

An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and delivered in the Emergency Room or an independent freestanding emergency department. These services are covered through stabilization and in some cases include admission to the facility.
- Non emergency and surgical and ancillary services (defined below) provided by an **out-of-network provider** at an in-network facility by certain types of providers. Providers other than the types below may balance bill you if the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
  - Signed consent from you to be treated and balance-billed by the **out-of-network provider**
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:

- **Surgery**, including assistants
- Anesthesiology
- Pathology
- Radiology
- Hospitalist services
- Laboratory services
- Neonatology
- Emergency Medicine
- Other provider types as may be added under Federal Law

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

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

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the **out-of-network provider** based on the median in-network rate or such other data resources or factors as determined by Aetna.

Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network **deductible** and out-of-pocket maximum, if you have one.

Certain **out-of-**network providers may ask you to sign a consent form to allow them to balance bill you for services above any amounts covered by your plan. In this case, you may be responsible for all charges from that out-of-network provider.

You may request external review if you are seeking to determine if the No Surprises Act applies to your situation.

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

Paying for covered services – the general requirements

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

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

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

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

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

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

You pay the entire expense when:

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

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

Where your schedule of benefits fits in

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

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

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

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan 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 will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about "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
- An automobile insurance policy
- Medicare or other government benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
  - We pay benefits after the primary plan and reduce our payment based on any amount the primary plan paid.
  - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information.

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

COB rule	Primary plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent

COB rule	Primary plan	Secondary plan
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	• Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent's plan if there is no court order	• Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent's plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare, even if you are not covered, if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. See the schedule of benefits for more information.

Your current and prior plan must be offered through the same employer.

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.

Our rights
We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

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

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

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

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

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

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

Concurrent care claim extension
A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

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

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

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

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

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

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

Complaints, claim decisions and appeals procedures

The difference between a complaint and an appeal

A Complaint

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

An Appeal

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

Claim decisions and appeal procedures

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

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

Appeals of adverse benefit determinations

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

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

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

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

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

Urgent care or pre-service claim appeals

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

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

Timeframes for deciding appeals

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

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

Exhaustion of appeals process

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

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

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

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

External review

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

You have a right to external review only if:

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

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

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

You must submit the Request for External Review Form:

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

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

Aetna will:

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

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

How long will it take to get an ERO decision?

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

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

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

For initial adverse determinations

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

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

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

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

When you can join the plan

You must live or work in the service area to enroll in this plan.

You can enroll:

- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your "dependents") at this time too.
If you don't enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Dependent children – yours or your spouse's
  - Dependent children must be:
    - Under 26 years of age
  - Dependent children include:
    - Natural children
    - Stepchildren
    - Adopted children including those placed with you for adoption
    - Foster children
    - Children you are responsible for under a qualified medical support order or court order
    - Grandchildren in your legal custody

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan

- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:
- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state fee assistance under Medicaid or S-CHIP which will pay your fee contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status
Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:
- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage
Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your employer to confirm your effective date.

Stopping coverage
Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end
Your coverage under this plan will end if:
- This plan is no longer available
- You ask to end coverage
- Your employer asks to end coverage
- You are no longer eligible for coverage, including when you move out of the service area
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage
- You start coverage under another medical plan offered by your employer

When dependent coverage ends
Dependent coverage will end if:
- A dependent is no longer eligible for coverage.
- You stop making contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
  - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.

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 coverage ends* section for more information.

Why would we end your coverage?
We may immediately end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

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

Special coverage options after your coverage ends
When coverage may continue under the plan
This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact your employer to see what options apply to you.

In some cases, fee payment is required for coverage to continue. Your coverage will continue under the plan as long as your employer and we have agreed to do so. It is your employer's responsibility to let us know when your work ends. If your employer and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:
- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

How you can extend coverage for your disabled child beyond the plan age limits
You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of mental or physical disability and depends mainly (more than 50% of their 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 you can extend coverage for hearing services and supplies when coverage ends
If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet

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

How Aetna administers this plan

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

Who's responsible to you

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

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

Claim administrator

Aetna's authority as claim administrator

Aetna has been delegated the authority to make claim and appeal determinations under the Plan. In exercising this responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Coverage and services

Your coverage can change

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

Physical examination and evaluations

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

Records of expenses

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

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

Honest mistakes and intentional deception

Honest mistakes

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

Intentional deception

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

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

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

You have special rights if we rescind your coverage:

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

Some other money issues

Legal action

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

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

Assignment of benefits

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

Financial sanctions exclusions

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

Recovery of overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. One of the ways Aetna recovers overpayments is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by Aetna. Aetna would then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan may be subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

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.

Your health information

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

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

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

Sutter Health and Affiliates Services

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental 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

Behavioral health provider

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

Brand-name prescription drug

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

Copay, copayment

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

Covered service

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

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

Deductible

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

Detoxification

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

Drug guide

A list of **prescription** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html

Emergency medical condition

An acute, severe medical condition that:

- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby

Emergency services

Treatment given in a **hospital's** emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Experimental or investigational

Drugs, treatments or tests not yet accepted by **physicians** or by insurance plans as standard treatment. They may not be proven as effective or safe for most people.

A drug, device, procedure, or treatment is **experimental or investigational** if:

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

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
- Safety
- Strength
- Quality
- Performance

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can **stay** overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:

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

Jaw joint disorder

This is:

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

Mail order pharmacy

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

Maximum out-of-pocket limit

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

Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

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

Generally accepted standards of medical practice means:

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

Important note:
We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the *Contact us* section for how.

Mental health disorder

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

Negotiated charge

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

Network provider

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

Out-of-network provider

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

Payment Percentage

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

Physician

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

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Prescription

This is an instruction written by a **physician** or other **provider** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care physician (PCP)

A **physician** who:

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

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

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

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

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

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

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

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

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

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For substance related residential treatment programs:

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

For **detoxification** programs within a residential setting:

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

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

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

Semi-private room rate

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

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care.
Skilled nursing facilities also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

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

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

Specialist

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

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

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

Stay

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

Substance related disorder

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

Surgery, surgical procedure

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

- Cutting
- Abrading
- Suturing

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

Telemedicine

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

Terminal illness

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

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
- Emergency room
- **Hospital**
- Outpatient department of a **hospital**
- **Physician's** office
- Urgent care facility

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

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

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

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

Notice Regarding Women's Health and Cancer Rights Act

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

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

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

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

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Schedule of benefits

Prepared for:

Employer:	Gwinnett County Board of Commissioners
Contract number:	MSA-0737528
Plan name:	Aetna Choice POSII Bronze Max
Schedule of benefits:	1D
Plan effective date:	January 1, 2023
Plan issue date:	March 17, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

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

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

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

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

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

Plan features

Precertification covered services reduction
This only applies to **out-of-network covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

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

- A $500 benefit reduction applied separately to each type of **covered service**

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

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

Deductible type	In-network	Out-of-network
Individual (Employee Only Plan)	$3,900 per Calendar year	$7,800 per Calendar year
Individual (Family Plan)	$3,900 per Calendar year	$15,600 per Calendar year
Family	$7,800 per Calendar year	$15,600 per Calendar year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

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

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

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual (Employee only)	$6,900 per year	$13, 800 per year
Individual (Family Plan)	$6,900 per year	$27,600 per year
Family	$13, 800 per year	$27, 600 per year

General coverage provisions

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

Deductible provisions

Covered services that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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

Employee Only In-Network Deductible

For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage.

Individual deductible

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

Employee Only Out-of-Network Deductible
For purposes of the Calendar Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage

Individual
This is the amount you owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Employee and Family In-Network and Out-of-Network Deductible

- The family **deductible** can be met by one family member, or a combination of family members.

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

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

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Employee Only Plan In-Network Maximum Out-of-Pocket
The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit
After the amount of the cost share and **deductible** paid during the year for **covered services** meets the individual **maximum out-of-pocket limit,** this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for you for the remainder of the year.

Employee Only Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self only coverage with no dependents coverage

Employee and Family Plan In-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

Employee and Family Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents. The family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family.

Family

Once the amount of the **maximum out-of-pocket limit** and **deductibles** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Outpatient prescription drug deductible provisions

Covered services that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

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

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year	30	30

Ambulance services

Description	In-network	Out-of-network
Emergency services	70% per trip after **deductible**	50% per trip after **deductible**
Description	**In-network**	**Out-of-network**
Non-emergency services	70% per trip after **deductible**	50% per trip, after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	70% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	70% per visit after **deductible**	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	70% per visit after **deductible**	50% per visit after **deductible**

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	70% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	70% per visit after **deductible**	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	70% per visit after **deductible**	50% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	70% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	70% per visit after **deductible**	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Habilitation therapy services

Physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network	Out-of-network
PT, OT and ST therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	70% per item after **deductible**	50% per item after **deductible**
Limit	One per ear every 36 months	One per ear every 36 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per Calendar year	60	60

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

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% after **deductible**	50% after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	70% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	70% after **deductible**	50% after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Not covered

Outpatient prescription drug important note:

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	70% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	70% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	70% per visit after **deductible**	50% per visit after **deductible**
Physician surgical services	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	70% per visit after **deductible**	50% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	70% per visit after **deductible**	50% per visit after **deductible**
Specialist surgical services	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	70% per visit after **deductible**	50% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	70% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	50% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit
Immunizations	100%, no **deductible** applies	100% no **deductible applies**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines	Subject to any age limits provided for in the comprehensive guidelines

	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health

	Resources and Services Administration	Resources and Services Administration

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	70% per item after **deductible**	50% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year All therapies combined In-network and out-of-network combined	60	60

Spinal manipulation

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	30	30

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	70% per admission after **deductible**	50% per admission after **deductible**

Day limit per year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	70% per transplant after **deductible**	50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	70% per visit after **deductible**	50% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	In-network	Out-of-network
Non-emergency services	70% per visit, after **deductible**	50% per visit after **deductible**
Preventive immunizations	100% per visit, no **deductible** applies	50% per visit after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

Schedule of benefits

Prepared for:

Employer:	Gwinnett County Board of Commissioners
Contract number:	MSA-0737528
Plan name:	Aetna Choice POSII Gold Max
Schedule of benefits:	1A
Plan effective date:	January 1, 2023
Plan issue date:	March 17, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

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

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

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

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

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

Plan features

Precertification covered services reduction
This only applies to **out-of-network covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

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

- A $500 benefit reduction applied separately to each type of **covered service**

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

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

Deductible type	In-network	Out-of-network
Individual	$1,550 per year	$3,100 per year
Family	$3,100 per year	$6,200 per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

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

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

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$2 800 per year	$5,600 per year
Family	$5,600 per year	$11,200 per year

General coverage provisions

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

Deductible provisions

Covered services that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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

Employee Only In-Network Deductible

For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage.

Individual deductible

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

Employee Only Out-of-Network Deductible

For purposes of the Calendar Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage

Individual

This is the amount you owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Employee and Family In-Network and Out-of-Network Deductible

- The family **deductible** can be met by one family member, or a combination of family members.

Family deductible

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

Payment Percentage

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

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Employee Only Plan In-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

After the amount of the cost share and **deductible** paid during the year for **covered services** meets the individual **maximum out-of-pocket limit,** this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for you for the remainder of the year.

Employee Only Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self only coverage with no dependents coverage

Employee and Family Plan In-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

Employee and Family Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents. The family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family.

Family

Once the amount of the **maximum out-of-pocket limit** and **deductibles** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Outpatient prescription drug deductible provisions

Covered services that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

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

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	85% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year	30	30

Ambulance services

Description	In-network	Out-of-network
Emergency services	85% per trip after **deductible**	50% per trip after **deductible**
Description	**In-network**	**Out-of-network**
Non-emergency services	85% per trip after **deductible**	50% per trip, after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	85% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	85% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	85% per visit after **deductible**	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	85% per visit after **deductible**	50% per visit after **deductible**

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	85% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	85% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	85% per visit after **deductible**	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	85% per visit after **deductible**	50% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	85% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	85% per visit after **deductible**	Paid same as in-network

Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Habilitation therapy services

Physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network	Out-of-network
PT, OT and ST therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	85% per item after **deductible**	50% per item after **deductible**

Limit	One per ear every 36 months	One per ear every 36 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	85% per visit after **deductible**	50% per visit after **deductible**

Visit limit per Calendar year	60	60

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

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	85% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Outpatient services	85% per visit after **deductible**	50% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	85% after **deductible**	50% after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	85% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	85% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	85% after **deductible**	50% after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	85% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	85% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	15%, after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	15%, after **deductible**	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	15%, after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	15%, after **deductible**	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	15%, after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	15%, after **deductible**	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Not covered

Outpatient prescription drug important note:

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	85% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	85% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	85% per visit after **deductible**	50% per visit after **deductible**
Physician surgical services	85% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	85% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	85% per visit after **deductible**	50% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	85% per visit after **deductible**	50% per visit after **deductible**
Specialist surgical services	85% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	85% per visit after **deductible**	50% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	85% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	50% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit
Immunizations	100%, no **deductible** applies	50% after **deductible**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines	Subject to any age limits provided for in the comprehensive guidelines

	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health

	Resources and Services Administration	Resources and Services Administration

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	85% per item after **deductible**	50% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year All therapies combined In-network and out-of-network combined	60	60

Spinal manipulation

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	30	30

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	85% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	85% per admission after **deductible**	50% per admission after **deductible**

Day limit per year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	85% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	85% per transplant after **deductible**	50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	85% per visit after **deductible**	50% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	In-network	Out-of-network
Non-emergency services	85% per visit, after **deductible**	50% per visit after **deductible**
Preventive immunizations	100% per visit, no **deductible** applies	100% per visit no **deductible applies**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

Schedule of benefits

Prepared for:

Employer:	Gwinnett County Board of Commissioners
Contract number:	MSA-0737528
Plan name:	Aetna Choice POSII Silver Max
Schedule of benefits:	1B
Plan effective date:	January 1, 2023
Plan issue date:	March 17, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

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

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

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

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

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

Plan features

Precertification covered services reduction
This only applies to **out-of-network covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

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

- A $500 benefit reduction applied separately to each type of **covered service**

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

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

Deductible type	In-network	Out-of-network
Individual	$2,350 per Calendar year	$4,700 per Calendar year
Family	$4,700 per Calendar year	$9,400 per Calendar year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

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

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

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Employee Only Plan		
Individual	$4,900 per Calendar year	$9,800 per Calendar year
Employee and Family Plan		
Individual	$6,900 per Calendar Year	$19,600 per Calendar year
Family	$9,800 per Calendar year	$19,600 per Calendar year

General coverage provisions

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

Deductible provisions

Covered services that are subject to the **deductible** include those provided under the medical plan and the **prescription** drug plan.

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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

Employee Only In-Network Deductible
For purposes of the Calendar Year **deductible** provision below, an individual means an employee enrolled for self only coverage with no dependent coverage.

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

Employee Only Out-of-Network Deductible
For purposes of the Calendar Year deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage

Individual
This is the amount you owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you pay for **eligible health services** reaches this individual Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Employee and Family In-Network and Out-of-Network Deductible
- The family **deductible** can be met by one family member, or a combination of family members.

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

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

Maximum out-of-pocket limit
The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Employee Only Plan In-Network Maximum Out-of-Pocket
The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

After the amount of the cost share and **deductible** paid during the year for **covered services** meets the individual **maximum out-of-pocket limit,** this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for you for the remainder of the year.

Employee Only Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The individual **maximum out-of-pocket limit** applies to a person enrolled for self only coverage with no dependents coverage

Employee and Family Plan In-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **maximum out-of-pocket limit** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

Employee and Family Plan Out-of-Network Maximum Out-of-Pocket

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **maximum out-of-pocket limit** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out of pocket limit.**

For purposes of the following **maximum out-of-pocket limit** provisions:

- The family **maximum out-of-pocket limit** applies to a person enrolled with one or more dependents. The family **maximum out-of-pocket limit** can be met by a combination of family members or by any single individual within the family.

Family
Once the amount of the **maximum out-of-pocket limit** and **deductibles** paid during the Calendar Year for **eligible health services** meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the family's **covered benefits** that apply toward the limit for the rest of the Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment**/**payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Outpatient prescription drug deductible provisions

Covered services that are subject to the **deductible** include **covered services** provided under the medical plan and the **prescription** drug plan.

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

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year	30	30

Ambulance services

Description	In-network	Out-of-network
Emergency services	70% per trip after **deductible**	50% per trip after **deductible**
Description	**In-network**	**Out-of-network**
Non-emergency services	70% per trip after **deductible**	50% per trip, after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	70% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	70% per visit after **deductible**	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	70% per visit after **deductible**	50% per visit after **deductible**

Substance related disorders treatment

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

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	70% per visit after **deductible**	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	70% per visit after **deductible**	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your **deductible**	70% per visit after **deductible**	50% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	70% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	70% per visit after **deductible**	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Habilitation therapy services

Physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network	Out-of-network
PT, OT and ST therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	70% per item after **deductible**	50% per item after **deductible**
Limit	One per ear every 36 months	One per ear every 36 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per Calendar year	60	60

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

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% after **deductible**	50% after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	70% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	70% after **deductible**	50% after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	30% after **deductible**	Not covered
90 day supply at a **mail order pharmacy**	30% after **deductible**	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Not covered

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	70% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	70% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	70% per visit after **deductible**	50% per visit after **deductible**
Physician surgical services	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	70% per visit after **deductible**	50% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	70% per visit after **deductible**	50% per visit after **deductible**
Specialist surgical services	70% per visit after **deductible**	50% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	70% per visit after **deductible**	50% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	70% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 per 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 12 months to replace an existing electric pump	Electric pump: 12 months to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	50% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit
Immunizations	100%, no **deductible** applies	100% no **deductible applies**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines	Subject to any age limits provided for in the comprehensive guidelines

	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health

	Resources and Services Administration	Resources and Services Administration

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	70% per item after **deductible**	50% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year All therapies combined In-network and out-of-network combined	60	60

Spinal manipulation

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	30	30

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	70% per admission after **deductible**	50% per admission after **deductible**

Day limit per year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	70% per transplant after **deductible**	50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	70% per visit after **deductible**	50% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	In-network	Out-of-network
Non-emergency services	70% per visit, after **deductible**	50% per visit after **deductible**
Preventive immunizations	100% per visit, no **deductible** applies	100% per visit no **deductible applies**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and counseling services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB

Schedule of benefits

Prepared for:

Employer:	Gwinnett County Board of Commissioners
Contract number:	MSA-0737528
Plan name:	Aetna Choice POSII Traditional Plan
Schedule of benefits:	1C
Plan effective date:	January 1, 2023
Plan issue date:	August 15, 2023

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

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

How your cost share works

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

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

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

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

Under this plan, you will:

1. Pay your **copayment**
2. Then pay any remaining **deductible**
3. Then pay your **payment percentage**

Your **copayment** does not apply to any **deductible**.

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

How your PCP or physician office visit cost share works
You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

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

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

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

Plan features

Precertification covered services reduction
This only applies to **out-of-network covered services**:
Your booklet contains a complete description of the **precertification** process. You will find details in the *Medical necessity and precertification* section.

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

- A $500 benefit reduction applied separately to each type of **covered service**

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

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

Deductible type	In-network	Out-of-network
Individual	$1,600 per year	$3,200 per year
Family	$3,200 per year	$6,400 per year

Deductible waiver
There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Deductible and cost share waiver for risk reducing breast cancer prescription drugs

The **prescription** drug **deductible** and per **prescription** cost share will not apply to risk reducing breast cancer **prescription** drugs when obtained at a network pharmacy. This means they will be paid at 100%.

Deductible and cost share waiver for contraceptives (birth control)

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

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

Deductible and cost share waiver for tobacco cessation prescription and OTC drugs

The **prescription** drug **deductible** and the per **prescription** cost share will not apply to the first two 90-day treatment programs for tobacco cessation **prescription** and OTC drugs when obtained at a network **retail pharmacy**. This means they will be paid at 100%. Your per **prescription** cost share will apply after those two programs have been exhausted.

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	$4,200 per year	$8,400 per year
Family	$8,400 per year	$16,800 per year

General coverage provisions

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

Deductible provisions

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

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

Individual deductible

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

Family deductible

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

this happens in a year, the individual **deductibles** for you and your covered dependents are met for the rest of the year.

Copayment

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

Payment Percentage

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

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. **Covered services** that are subject to the **maximum out-of-pocket limit** include those provided under the medical plan and the outpatient **prescription** drug plan.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

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

Family maximum out-of-pocket limit

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

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

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

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

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

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

Outpatient prescription drug maximum out-of-pocket limit provisions

Covered services that are subject to the **maximum out-of-pocket limit** include **covered services** provided under the medical plan and the **prescription** drug plan.

The **maximum out-of-pocket limit** is the most you will pay per year in **copayments**, **payment percentage** and **deductible**, if any, for **covered services**. This plan may have an individual and family **maximum out-of-pocket limit**.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	70% per visit after **deductible**	50% per visit after **deductible**

Visit limit per year	30	30

Ambulance services

Description	In-network	Out-of-network
Emergency services	70% per trip after **deductible**	50% per trip after **deductible**
Description	**In-network**	**Out-of-network**
Non-emergency services	70% per trip after **deductible**	50% per trip, after **deductible**

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Treatment	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Behavioral health

Mental health treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-**room and board** including **residential treatment facility**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Outpatient **mental health disorders telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies	50% per visit after **deductible**

Substance related disorders treatment

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

Description	In-network	Out-of-network
Inpatient services-**room and board** during a **hospital stay**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient office visit to a **physician** or **behavioral health provider**	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Physician or **behavioral health provider telemedicine** consultation	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Outpatient **telemedicine** cognitive therapy consultations by a **physician** or **behavioral health provider**	Covered based on type of service and **provider** from which it is received	Covered based on type of service and **provider** from which it is received

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services	100% per visit, no **deductible** applies	50% per visit after **deductible**

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Routine patient costs	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	70% per item after **deductible**	50% per item after **deductible**

Emergency services

Description	In-network	Out-of-network
Emergency room	70% per visit after **deductible**	Paid same as in-network
Non-emergency care in a **hospital** emergency room	Not covered	Not covered

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

Habilitation therapy services

Physical (PT), occupational (OT) and speech (ST) therapies

Description	In-network	Out-of-network
PT, OT and ST therapies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing aids

Description	In-network	Out-of-network
Hearing aids	70% per item after **deductible**	50% per item after **deductible**
Limit	One per ear every 36 months	One per ear every 36 months

Hearing exams

Description	In-network	Out-of-network
Hearing exams	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Visit limit	1 visit every 24 months	1 visit every 24 months

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	70% per visit after **deductible**	50% per visit after **deductible**
Visit limit per year	60	60

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

Hospice care

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% after **deductible**	50% after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Limit per lifetime	unlimited	unlimited

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

Hospital care

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% after **deductible**	50% after **deductible**

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic **infertility**	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Services performed in **physician** or **specialist** office or a facility	70% per visit after **deductible**	50% per visit after **deductible**
Other services and supplies	70% after **deductible**	50% after **deductible**

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

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – **room and board**	70% per admission after **deductible**	50% per admission after **deductible**

Description	In-network	Out-of-network
Outpatient services	70% per visit after **deductible**	50% per visit after **deductible**

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$20, no **deductible** applies	Not covered
31-90 day supply at a **mail order pharmacy**	$40, no **deductible** applies	Not covered

Preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$50, no **deductible** applies	Not covered
31-90 day supply at a **mail order pharmacy**	$100, no **deductible** applies	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30 day supply at a **retail pharmacy**	$75, no **deductible** applies	Not covered
31-90 day supply at a **mail order pharmacy**	$150, no **deductible** applies	Not covered

Contraceptives (birth control)

Brand-name prescription drugs and devices are covered at 100% when a generic is not available

Description	In-network	Out-of-network
30 day supply of generic and OTC drugs and devices	$0, no **deductible** applies	Not covered
30 day supply of **brand-name prescription drugs** and devices	Paid based on the tier of drug in the schedule	Not covered

Preventive care drugs and supplements

Description	In-network	Out-of-network
Preventive care drugs and supplements	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of covered preventive care drugs and supplements or more information, see the *Contact us* section	Not covered

Risk reducing breast cancer drugs

Description	In-network	Out-of-network
Risk reducing breast cancer **prescription** drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF) For a current list of risk reducing breast cancer drugs or more information, see the *Contact us* section	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation **prescription** and OTC drugs	$0, no **deductible** applies	Not covered
Limits	Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF. For a current list of covered tobacco cessation drugs or more information, see the *Contact us* section. See the *Other services* section of this schedule for more information.	Not covered

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

Outpatient surgery

Description	In-network	Out-of-network
At **hospital** outpatient department	70% per visit after **deductible**	50% per visit after **deductible**
At facility that is not a **hospital**	70% per visit after **deductible**	50% per visit after **deductible**
At the **physician** office	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Physician surgical services	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician telemedicine consultation	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

Description	In-network	Out-of-network
Physician visit during inpatient **stay**	70% per visit after **deductible**	50% per visit after **deductible**

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Specialist surgical services	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

Description	In-network	Out-of-network
Specialist telemedicine consultation	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

All other services not shown above

Description	In-network	Out-of-network
All other services	70% per visit after **deductible**	50% per visit after **deductible**

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support	100% per visit, no **deductible** applies	50% per visit after **deductible**
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the **physician** services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 12 months Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 1 year to replace an existing electric pump	Electric pump: 1 year to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for alcohol or drug misuse visit limit	5 visits/12 months	5 visits/12 months
Counseling for obesity, healthy diet	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for sexually transmitted infection visit limit	2 visits/12 months	2 visits/12 months
Counseling for tobacco cessation	100% per visit, no **deductible** applies	50% per visit after **deductible**
Counseling for tobacco cessation visit limit	8 visits/12 months	8 visits/12 months
Family planning services (female contraception counseling)	100% per visit, no **deductible** applies	50% per visit after **deductible**
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting Counseling's that exceed this limit are covered as a **physician** services office visit
Immunizations	100%, no **deductible** applies	100% no **deductible applies**
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines	Subject to any age limits provided for in the comprehensive guidelines

	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Routine cancer screenings	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your **physician** or see the *Contact us* section
Routine lung cancer screening	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine lung cancer screening limit	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing	1 screenings every 12 months Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every 12 months after that age, up to age 22; 1 exam every 12 months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no **deductible** applies	50% per visit after **deductible**
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health

	Resources and Services Administration	Resources and Services Administration

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	70% per item after **deductible**	50% per item after **deductible**

Reconstructive surgery and supplies

Including breast **surgery**

Description	In-network	Out-of-network
Surgery and supplies	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Short-term rehabilitation services

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

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Physical, occupational and speech therapies

Description	In-network	Out-of-network
	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

Physical, occupational and speech therapies

Description	In-network	Out-of-network
Visit limit per year All therapies combined In-network and out-of-network combined	60	60

Spinal manipulation

Description	In-network	Out-of-network
	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**

Visit limit per year In-network and out-of-network combined	30	30

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - **room and board**	70% per admission after **deductible**	50% per admission after **deductible**
Other inpatient services and supplies	70% per admission after **deductible**	50% per admission after **deductible**

Day limit per Calendar year	60	60

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic lab work

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	70% per visit after **deductible**	50% per visit after **deductible**

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

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

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

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes **providers** who are otherwise part of Aetna's network but are non-IOE **providers**)
Inpatient services and supplies	70% per transplant after **deductible**	50% per transplant after **deductible**
Physician services	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**
A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of- network
Urgent care facility	$75 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Non-urgent use of an urgent care facility or **provider**	Not covered	Not covered

Walk-in clinic

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

Description	In-network	Out-of-network
Non-emergency services	$50 then the plan pays 100% per visit, no **deductible** applies	50% per visit after **deductible**
Preventive immunizations	100% per visit, no **deductible** applies	50% per visit after **deductible**
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your **physician**
Screening and	100% per visit, no **deductible** applies	50% per visit after **deductible**

counseling services		
Screening and counseling limits	See the *Preventive care services* section of the SOB	See the *Preventive care services* section of the SOB