

Choice POS II medical plan

Booklet

Prepared for:

Employer:	Sysco Corporation
Contract number:	MSA-0169618
Control number:	0169618
Plan name:	HSA Plan
Booklet:	1
Plan effective date:	July 1, 2022
Plan issue date:	July 1, 2022

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

Table of contents

Welcome	3
Coverage and exclusions.....	4
General plan exclusions	30
How the Plan works	36
Complaints, claim decisions and appeals procedures	48
Eligibility, starting and stopping coverage	52
General provisions – other things you should know.....	54
Glossary	59
Schedule of Benefits	70

WELCOME

Introduction

This booklet describes your **covered services** – what they are and how to get them. It also describes how the Plan managed, according to policies, and applicable laws and regulations. The schedule of benefits tells you how expenses are shared for **covered services** and explains any limits. Together, these documents describe the benefits covered by the Sysco Corporation Group Benefits Plan (“the Plan”). Each may have amendments attached to them. These changes 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, please contact the Aetna Health Advocates at 833-361-0223.

How we use words

When the Plan uses:

- “You” and “your” we mean you and any covered dependents (if the Plan allows dependent coverage)
- Words that are in bold are defined in the *Glossary* section

Contact us

The Plan includes the Aetna Advocate Program and provides immediate access to advocates trained in the specific details of the Plan.

For questions about the Plan, you can contact the Aetna Health Advocates by :

- Calling 1-833-361-0223
- Writing us at 151 Farmington Ave, Hartford, CT 06156
- Visiting <https://www.aetna.com> to access your member website

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

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

Your ID card

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

COVERAGE AND EXCLUSIONS

Providing covered services

The 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 the Plan works – Medical necessity and pre-certification 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 are limited or aren't covered at all. 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 per 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 **pre-certification** from us. For more information see the *How your plan works – Medical necessity and pre-certification 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 the Aetna Health Advocates at 833-361-0223. You can find out about limitations for **covered services** in the schedule of benefits.

Acupuncture

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

The following are not **covered services**:

- Acupuncture, other than for anesthesia
- Acupressure

Ambulance services

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

Emergency 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 Ambulance

Covered services also include pre-certified 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 certain early intensive behavioral interventions such as applied behavior analysis.

Applied behavior analysis is an educational service that is the process of applying interventions that:

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

Important note:

Applied behavior analysis may require **pre-certification** by us. See the *How your plan works – Medical necessity and pre-certification* 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

Important note:

Some services require **pre-certification** by us. For more information see the *How your plan works – Medical necessity and pre-certification* section.

Behavioral health

Mental health disorders 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** (the 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 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

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** (the 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**
 - Ambulatory or outpatient **detoxification** which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
 - Observation
 - Peer counseling support by a peer support specialist

Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided, or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Clinical trials**Routine patient costs**

Covered services include routine patient costs you incur 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 Aetna's 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 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 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

The Plan only covers the same type of DME that Medicare covers, however, there are some DME items Medicare covers that the 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.

Your coverage for **emergency services** will continue until your condition is stabilized and:

- Your attending **physician** determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another **provider** if you need more care
- You are in a condition to be able to receive from the **out-of-network provider** delivering services the notice and consent criteria with respect to the services
- Your **out-of-network provider** delivering the services meets the notice and consent criteria with respect to the services

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

Non-emergency services

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

Foot orthotic devices

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

Gender affirming treatment

Covered services include certain services and supplies for gender affirming (sometimes called sex change) treatment.

Important note:

Log into your **Aetna** website at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for detailed information about this **covered benefit**, including eligibility and medical necessity requirements. You can also call *Member Services* at the telephone number on the back of your I.D. card.

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 must 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 for adults and children per 5 years 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 adults and children every 24 months, 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 the following criteria are met:

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

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

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

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

The following are not **covered services**:

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

Important note:

Some services require **pre-certification** by us. For more information see the *How your plan works – Medical necessity and pre-certification* section.

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.
- Artificial insemination services.

Institutes of Quality

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

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

Institutes of Quality Cardiac Care

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

Cardiac IOQ facilities provide the following services:

- Rhythm
 - Pacemakers - small battery-powered device that sends weak electrical impulses to enable heart to keep a regular heartbeat
 - Defibrillator - small battery-powered device used to treat an abnormal heart rhythm or rate
- Interventional
 - Heart Catheterization - procedure performed to show blood flow through heart chambers and arteries
 - PTCA - balloon opening artery of heart
 - Stent - small expandable tube used to keep an artery open to increase blood flow
- Surgery
 - CABG, Valve w/ CABG, Valve w/out CABG - repairing or replacing the damaged flaps inside the heart to allow blood to flow more easily and in the right direction

Institutes of Quality Orthopedic Care

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

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

- Spine
 - Primary Fusion - surgery to join or fuse two or more vertebrae together
 - Fusion Revision - surgery done when the first operation to fuse the vertebrae does not work

- Discectomy (w/out decompression) - removal of protruding disc material that is pressing on a nerve or the spinal cord
- Decompression (w/out fusion) - removal of bony growths or parts of vertebrae to enlarge spinal canal to relieve pressure on nerve roots
- Total Joint Replacement
 - Knee Replacement - replacement of both damaged bone ends of the joint and kneecap with artificial material
 - Hip Replacement - replacement of the damaged joint with an implant

Jaw joint disorder treatment

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

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

The following are not **covered services**:

- Tooth reconstruction

Maternity and related newborn care

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

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

If the mother is discharged earlier, the plan will pay for 1 home visit after delivery by a health care **provider**.

Covered services also include services and supplies needed for circumcision by a **provider**.

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

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

- Cutting out:
 - 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

Important note:

Log into your **Aetna** website for detailed information about this **covered benefit**, including eligibility and medical necessity requirements. You can also call the Aetna Health Advocates at 1-833-361-0223.

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 services require pre-certification by us. For more information see *How your plan works – Medical necessity and pre-certification* section.

Some surgeries can be done safely in a **physician's** office. For those surgeries, the 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
- By way of **telemedicine**

Important note:

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

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

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

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

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.

The 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 the Aetna Health Advocates at 1-833-361-0223.

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

Prescription drug synchronization

Prescription drug synchronization is when a pharmacist coordinates the refill of your maintenance medications so you can pick them up on a single day each month, your CVS pharmacy can coordinate that for you. A prorated daily cost share will apply, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs.

How to access network pharmacies

You can find a CVS network pharmacy either by logging on to Aetna.com or contacting the Aetna Health Advocates at 1-833-361-0223.

Some **prescription** drugs are subject to quantity limits. This helps your **provider** and pharmacy ensure your **prescription** drug is being used correctly and safely. The Plan relies on medical guidelines, FDA-approved recommendations and other criteria developed 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**, unless the prescribing provider states dispense as written. Your cost share may be less if you use a **generic drug** when it is available.

Pharmacy types

Retail pharmacy

A CVS network **retail pharmacy** may be used for a one-time fill **prescription** drugs. A CVS network **retail pharmacy** will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit. All **prescription** refills, after the second refill at a CVS network **retail pharmacy**, must be filled at CVS retail pharmacy or through CVS Caremark Mail Service Pharmacy.

Maintenance Prescriptions (90-day supply)

Maintenance drugs are those you take on a regular basis for a chronic or long-term medical condition. Each **prescription** and refill are limited to a maximum 90-day supply. Maintenance prescriptions must be filled at a CVS retail pharmacy or through CVS Caremark Mail Service Pharmacy. Please note, you will be allowed two initial fills (30-day supply) of prescriptions intended to be taken long-term at any CVS network pharmacy. After the two initial fills, the maintenance drug will only be covered under the Plan if filled through a CVS network

pharmacy or CVS Caremark Mail Service Pharmacy. 90-day supply prescriptions will offer you the biggest cost savings, in most situations.

Specialty pharmacy

Specialty prescription drugs are only covered when filled through a CVS Caremark specialty pharmacy.

Each **prescription** is limited to a maximum 30-day supply. You can view the list of **specialty prescription drugs** by logging on to Aetna.com or contacting the Aetna Health Advocates at 1-833-361-0223.

All **specialty prescription drug** fills including the initial fill must be filled at a CVS network **specialty pharmacy**.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by Aetna, 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 CVS network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Some **specialty prescription drugs** may qualify for third-party **copayment** assistance programs that could lower your out-of-pocket costs. CVS Specialty® will provide you with support and resources to help you pursue third-party copayment assistance that may be available for your specialty drug. Any manufacturer coupon or rebate assistance amount received through one of these programs will not apply towards your **deductible** or **maximum out-of-pocket limit**. Contact CVS Specialty® through the Aetna Health Advocates at 1-833-361-0223 for more information on co-payment assistance programs that may be available to you.

Prudent Rx

You will automatically be enrolled in the Plan's copayment assistance program administered by PrudentRx (but you can choose to opt-out by contacting PrudentRx). The PrudentRx Copay Program will assist you by helping you to enroll in these drug manufacturer copay assistance programs. If you or a covered family member are taking one or more medications included in the PrudentRx Copay Program drug list, PrudentRx will contact you with specific information about the program as it relates to your medication and will let you know if you are required to enroll in copay assistance for any medication that you take. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx to provide any additional information needed to enroll in the copay program.

If you enroll to get copayment assistance for your eligible specialty medications, you will have a \$0 out-of-pocket responsibility for prescriptions covered under the PrudentRx Copay Program. Otherwise, if you do not return PrudentRx's call, if you choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for the full co-insurance on specialty medications as specified in your Schedule of Benefits. Copayments for these medications, whether made by you, your Plan, or the copay assistance program, will not count toward your plan deductible or out-of-pocket maximum.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

What if the pharmacy you use leaves the CVS network

Sometimes a pharmacy might leave the CVS network. If this happens, you will have to get your **prescriptions** filled at another CVS network pharmacy. You can use your **provider** directory or call the Aetna Health Advocates at 1-833-361-0223 to find another CVS 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 the Plan's service area. If you must fill a **prescription** in any of these situations, the Plan will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
A CVS network pharmacy	The plan cost share
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 Aetna, 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

Anti-cancer drugs taken by mouth, including chemotherapy drugs

Covered services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

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. Contraceptive prescriptions are considered a maintenance fill and will only be covered by the Plan if filled through a CVS network pharmacy or through CVS Caremark Mail Service Pharmacy after two 30-day initial fills. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices by logging on to Aetna.com or contacting the Aetna Health Advocates at 1-833-361-0223.

The Plan also covers 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, the Plan 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 Aetna 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 CVS network pharmacy by logging on to Aetna.com or contacting the Aetna Health Advocates at 1-833-361-0223. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Obesity drugs

Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents. You must have a **prescription** and get it filled at a CVS network pharmacy.

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
- 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 the Plan has approved a medical exception
 - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription** drug unless the Plan approved 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 Aetna’s **pre-certification** 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
 - 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:**
 - **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
 - The Plan reserves 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**

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 the Aetna Health Advocates at 1-833-361-0223. 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.

Breastfeeding support and counseling services

Covered services include assistance and training in breastfeeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breastfeeding 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** 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 provided, administered, or removed by a **physician** during an office visit.
- 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.

Family planning services – other

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

- Voluntary sterilization for males

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

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, including 3-D; if determined medically necessary, a screening MRI and comprehensive ultrasound
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies
- Cervical cancer

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 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
 - Autism screening as part of a routine physical exam
 - Hepatitis C and B screening
 - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

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

Well woman preventive visits

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

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

Private duty nursing - outpatient

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

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**

- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

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

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

Coverage includes:

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

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

The following are not **covered services**:

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

Reconstructive breast surgery and supplies

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

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

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 must 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 **pre-certified** 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 Aetna's **telemedicine provider** listing and contact the Aetna Health Advocates at 1-833-361-0223 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.

Imaging may require pre-certification and medical necessity review.

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 used in this section to 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 called “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.
- All 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:

To find a GCIT-designated facility/**provider** contact the Aetna Advocates at 1-833-361-0223, so they can help you determine if there are other facilities that may meet your needs.

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 the Aetna Advocates at 1-833-361-0223 or Aetna.com.

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 Institute of Excellence (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

Facilities are designated 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 designated by the Plan to perform the transplant you need. Transplant services received from an Institute of Excellence (IOE) facility are subject to the network **deductible, copayment, coinsurance, 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-Institute of Excellence (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, coinsurance, deductible, maximum out-of-pocket**, and limits, unless stated differently in this booklet and schedule of benefits

Important note:

If there are no Institute of Excellence (IOE) facilities assigned to perform your transplant type in your network, it's important that you contact the Aetna Health Advocates so they can help determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility the Plan designates, your cost share will be higher.

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

The following are not **covered services**:

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

Travel and Lodging

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

- U.S. domestic travel and lodging expenses for you and one companion, to travel from your home to receive the **covered services** from a **network provider** (coach class air fare, train or bus travel are examples of covered services).
- The maximum lodging benefit is \$50 per person per night, up to a total maximum lodging benefit of \$100.

- Total maximum travel and lodging benefit is \$10,000 per **occurrence**.
- This travel and lodging benefit is not available for the following:
 - **Covered services** coordinated through the Institutes of Excellence™, Institutes of Quality, National Medical Excellence® or Gene-based, cellular and other innovative therapies (GCIT) programs

To be eligible for travel and lodging reimbursement, Aetna Health Advocates must first confirm a network provider is not available within 100 miles of your home and a travel and lodging claim form must be completed. To obtain this confirmation and the travel and lodging claim form, and for detailed information about these covered services, including specific eligibility requirements and any limitations, contact the Aetna Health Advocates at 1-833-361-0223. Receipt of prior confirmation from Aetna Health Advocates is not required to receive travel and lodging benefits for pregnancy termination services, however Aetna Health Advocates can still assist you with locating a **network provider**.

Urgent care services

Covered services include services and supplies to treat a non-emergent condition at 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

GENERAL PLAN EXCLUSIONS

The following are not **covered services** under the 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 for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and exclusions-Preventive care* section
- Pathological gambling, kleptomania, and pyromania

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 exclusions, 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 **deductible, copayment, coinsurance,** 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 the 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, flat foot conditions or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Hospitalization, services and supplies that are not medically necessary

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

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

- 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 the Plan works – Medical necessity and pre-certification 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

Inpatient Private Duty Nursing

Long Term Care Service, except for specified services under Hospice Care

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

Non-emergency care in an emergency room

Nutritional support

Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

Obesity surgery and services

Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Coverage and exclusions* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric **surgery**
- **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

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

- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section.

Routine exams and preventive services and supplies

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

Services not permitted 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.

Note that in some cases the plan may provide travel benefits for services affected by this exclusion. For detailed information about these excluded services, contact the Aetna Health Advocates at 1-833-361-0223.

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 over the counter
- Gum over the counter

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 THE 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

Aetna's **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 Aetna.com. There you'll find our online provider directory or contact the Aetna Health Advocates at 1-833-361-0223.

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**. The 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 **pre-certification**
- Your cost share will be higher

Who provides the care

Network providers

Aetna has contracted with **providers** in the service area to provide **covered services** to you. These **providers** make up the network for the 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 the Plan will pay the **network provider** directly for what the Plan owes.

Your PCP

Your **PCP** will coordinate your medical care, or may provide treatment, or they may send you to other **network providers**. You can choose a PCP from the list of **PCPs** in our **directory**.

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

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 **allowable amount**, including balance-billing from the out-of-network provider
- Submitting your own claims and getting **pre-certification**

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

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

- You join the Plan and the **provider** who is currently treating you is not in the network
- You are already an Aetna member and your **provider** stops being in the Aetna network

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

If continuity of care is necessary, contact the Aetna Health Advocates for further assistance. If the continuity of care request is approved, you will be notified of the determined timeframe you can continue to see the **provider** at the in-network level. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

The Plan will authorize coverage only if the **provider** agrees to Aetna's usual terms and conditions for contracting **providers**.

Medical necessity and pre-certification requirements

The Plan pays a cost share of expenses 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 pre-certifies** the service when required

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where the Plan defines "**medically necessary, medical necessity,**" including an explanation on what the Plan considers **medically necessary**.

Important note:

The Plan covers **medically necessary, sex-specific covered services** regardless of identified gender.

Pre-certification

You need pre-approval from Aetna for some **covered services**. Pre-approval is also called **pre-certification**.

In-network

You and your physician's office are responsible for making sure a pre-certification is submitted prior to care. If the pre-certification is denied, and you still choose to receive care, you will be responsible for the full balance.

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **pre-certification** from Aetna. If you don't **pre-certify**:

- 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 **pre-certification** are listed below. For **emergency services**, **pre-certification** is not required, but you should notify us as shown.

To obtain **pre-certification**, contact the Aetna Health Advocates at 1-833-361-0223. You, your **physician** or the facility must call Aetna 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.

You and your **physician** will be notified in writing of the **pre-certification** 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, you, your **physician** and the facility will be notified about your **pre-certified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **pre-certified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. You and your **physician** will be notified in writing of an approval or denial of the extra days.

If you or your **provider** request **pre-certification** and coverage is not approved, you will receive an explanation of why and explain how you or your **provider** may request review of Aetna's decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require pre-certification

Pre-certification is required for inpatient **stays** and certain outpatient services and supplies.

Pre-certification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Gene-based, cellular and other innovative therapies (GCIT)	Applied behavior analysis
Gender affirming treatment	Complex imaging
Obesity (bariatric) surgery	Cosmetic and reconstructive surgery
Stays in a hospice facility	Emergency transportation by airplane
Stays in a hospital	Gene-based, cellular and other innovative therapies (GCIT)
Stays in a rehabilitation facility	Gender affirming treatment
Stays in a residential treatment facility for treatment of mental health disorders and substance related disorders	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
Stays in a skilled nursing facility	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
	Private duty nursing services
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist surgery

Contact the Aetna Health Advocates at 1-833-361-0223 to get a complete list of the services that require **pre-certification**. The list may change from time to time.

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

Aetna's clinical policy bulletins explain the policy for specific services and supplies. The bulletins and other resources are used to help guide individualized coverage decisions under the Plans. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>.

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **pre-certification** information applies to these **prescription** drugs:

- For certain drugs, your **provider** needs to get approval prior to the drug being covered under the Plan. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Step therapy is a type of **pre-certification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact Aetna or go online to get the most up-to-date **pre-certification** requirements and list of **step therapy** drugs.

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 Aetna. You will need to provide Aetna 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:

- Contact the Aetna Health Advocates at 1-833-361-0223
- 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** – the Plan, just you or both? 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 coinsurance.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

“Expense” in this general rule, refers to 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 the Plan has agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

Aetna may enter 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, Aetna has 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

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

If your 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	105% of the Medicare allowable rate
Inpatient and outpatient charges of hospitals	140% of the Medicare allowable rate
Inpatient and outpatient charges of facilities other than hospitals	
Prescription drugs	110% of the average wholesale price (AWP)

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.

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

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

- Performed at a network facility by certain **out-of-network providers**
- Not available from a **network provider**
- **Emergency services**

The Plan will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact Aetna Health Advocates immediately if you receive such a bill.

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.

Our reimbursement policies

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

These policies consider:

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

Our reimbursement policies may consider:

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

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

Get the most value out of your benefits

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

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** pre-certifies 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** pre-certifies 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, the 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 **pre-certification**, your **physician** requests it, we deny it and you get the services without **pre-certification**.
- You get care from an **out of-network provider** 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 the 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 **coinsurance**.

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 the Aetna Health Advocates at 1-833-361-0223 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
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

COB rule	Primary plan	Secondary plan
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 the Aetna Health Advocates at 1-833-361-0223 if you have any questions about this.

When you are eligible for Medicare, Aetna will coordinate the benefits the Plan pays with the benefits that Medicare pays. Sometimes, the 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.

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 the Aetna Health Advocates at 1-833-361-0223 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

Aetna and the Plan 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 the Plan 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 Aetna when you want or get **covered services**. There are different types of claims. You or your **provider** may contact Aetna 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 the 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 Aetna must inform you of the 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. Aetna 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 Aetna **pre-certifies** them. Aetna 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. Aetna will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need Aetna to approve more services than already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let Aetna know you need this extension 24 hours before the original approval ends. Aetna 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 Aetna decides to reduce or stop payment for an already approved course of treatment. Aetna 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 Aetna 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**, **coinsurance** and **deductibles** that apply to the service or supply. If Aetna upholds their decision at the final internal appeal, you will be responsible for all 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 Aetna 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 Aetna the bill within 12 months of the date you received services, unless you are legally unable to notify Aetna. You must send it to Aetna with a claim form that you can either get online or contact the Aetna Health Advocates at 1-833-361-0223 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 **coinsurance**, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. Aetna may need to ask you or your **provider** for some more information to make a final decision. You can always contact the Aetna Health Advocates directly to see how much you can expect to pay for any service.

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

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

COMPLAINTS, CLAIM DECISIONS AND APPEALS

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

Claim decisions and appeal procedures

Your **provider** may contact the Aetna Health Advocates 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 the decision. As states in the *Benefit payments and claims* in the *How the Plan works* section, Aetna pays many claims at the full rate, except for your share of the costs. But sometimes Aetna pays only some of the claim. Sometimes Aetna will deny payment entirely.

Any time Aetna denies 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 Aetna 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 the adverse benefit determination. Aetna 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 the Aetna Health Advocates at 1-833-361-0223. 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 Aetna to consider

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell Aetna 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 Aetna that you are allowing someone to appeal for you. You can get this form by contacting the Aetna Health Advocates at 1-833-361-0223. 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 Aetna that you are allowing the provider to appeal for you.

Aetna will provide you with any new or additional information that used or that developed by Aetna to review your claim. Aetna will provide this information at no cost to you before giving 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 Aetna provides a final decision.

Timeframes for deciding appeals

The amount of time that Aetna has to inform you of a 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 Aetna has to provide a decision.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (Aetna)	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 Aetna 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 Aetna's control.
 - The violation was part of an ongoing, good faith exchange between you and Aetna.

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:

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

If Aetna's claim decision is one for which you can seek external review, Aetna 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 Aetna
- And you must include a copy of the notice from Aetna and all other important information that supports your request

Aetna will:

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

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

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

How long will it take to get an ERO decision?

Aetna will inform you of the ERO decision not more than 45 calendar days after Aetna 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 Aetna or send Aetna 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 informs Aetna 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 Aetna 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

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

Fees and expenses

Aetna and the Plan do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

STARTING AND STOPPING COVERAGE

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 if 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.

If you have questions or need assistance with certifying a disabled dependent, please contact the Aetna Health Advocates at 1-833-361-0223.

When Coverage Begins

- The first of the month on or after 31 days of your date of hire
- The first of plan year if enrolled during annual enrollment
- The date defined in the Special Enrollment section based on the qualifying change in status

When Coverage Ends

The Sysco Benefits Center 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 paying required premiums, if any apply
- 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 paying premiums, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - Exhaustion of your overall maximum benefit.

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?

Aetna or the Plan 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.

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 the Sysco Benefits Center at 1-800-55-Sysco to see what options apply to you.

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

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

Aetna and the Plan prepared this booklet according to the Employee Retirement Income Security Act of 1974 (ERISA), as amended and other federal and state laws that apply. You, Aetna and the Plan will interpret it according to these laws. Also, you are bound by the interpretation of this booklet when Aetna administers your coverage.

How we administer this plan

Aetna and the Plan will apply policies and procedures developed to administer this plan.

Who's responsible to you

Aetna is responsible to you for what their employees and other agents do.

Aetna and the Plan are not responsible for what is done by your **providers**. Even **network providers** are not Aetna's employees or agents.

Coverage and services

Your coverage can change

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

Physical examination and evaluations

At Aetna's expense, Aetna have the right to have a **physician** of Aetna's 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 Aetna. 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 Aetna or the Plan learn that you defrauded Aetna and the Plan or you intentionally misrepresented material facts, Aetna and the Plan 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

Aetna 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 your coverage is rescinded:

- Aetna 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 the Plan has one, before you take any legal action against Aetna for any expense or bill. See the *Complaints, claim decisions, and, appeal procedures* section. You cannot take any action until 60 days after Aetna 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 Aetna directly. When you see an **out-of-network provider**, Aetna 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, Aetna 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

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

You can get a free copy of our *Notice of Privacy Practices*. Just contact the Aetna Health Advocates at 1-833-361-0223.

When you accept coverage under this plan, you agree to let your **providers** share information with us. Aetna needs 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

Copays are flat fees for certain visits. A **copay** can be a dollar amount or percentage.

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 the Plan works – Medical necessity and pre-certification 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 the Plan 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 Aetna 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

A severe medical condition that:

- Comes on suddenly
- 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. This includes evaluation of and treatment to stabilize the **emergency medical condition**.

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 identity disorder.

Institutes of Quality® (IOQ) (Orthopedic and Cardiac)

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

IOQ Cardiac Care services include Cardiac Medical Intervention, Heart Surgery and Heart Rhythm Disorders. IOQ Orthopedic Care services include Spine Surgeries and Total Joint Replacement.

Jaw joint disorder

This is:

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

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

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

Generally accepted standards of medical practice mean:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in Aetna's clinical policies and applying clinical judgment

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 the 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**.

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)**.

Pre-certification, pre-certify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by Aetna as to whether the service is **medically necessary** and eligible for coverage.

Prescription

This is an instruction written by a **physician** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care 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 Aetna's 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, 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 the 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, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable 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

This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

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, 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.

Value prescription drugs

A group of medications determined by Aetna that may be available at a reduced **copayment** or **coinsurance** and are noted on the **drug guide**.

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

Additional Information Provided by

Sysco Corporation

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

Name of Plan:

Sysco Corporation Group Benefit Plan

Employer Identification Number:

74-1648137

Plan Number:

501

Type of Plan:

Welfare

Type of Administration:

Administrative Services Contract with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:

Sysco Corporation
1390 Enclave Parkway
Houston, TX 77077
Telephone Number: 800-55-SYSCO

Agent For Service of Legal Process:

Sysco Corporation Plan Administrative Committee
1390 Enclave Parkway
Houston, TX 77077

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

End of Plan Year:

December 31

Source of Contributions:

Employer and Employee

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the person designated by the Plan Administrator.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under ERISA, including that all plan participants shall be entitled to:

Receive Information about the Plan and Benefits

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

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

Assistance with Your Questions

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

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

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

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

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

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

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

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain pre-certification for any days of confinement that exceed 48 hours (or 96 hours). For information on pre-certification, contact the 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 the Plan's coverage of mastectomies and reconstructive surgery, please contact the Aetna Health Advocate at 1-833-361-0223.

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 Aetna's 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 the Aetna Health Advocates at 1-833-361-0223

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 the Aetna Health Advocates at 1-833-361-0223

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 exclusively for:

Employer: Sysco Corporation
Contract number: MSA-0169618
Control number: 0169618
Plan name: HSA Plan
Schedule of benefits: 1A
Plan effective date: January 1, 2022
Plan issue date: January 1, 2022

Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles, copayments** or **coinsurance**, 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. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

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
- **Coinsurance** 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 **coinsurance** that your plan will pay.
- You are responsible to pay any **deductibles, copayments** and remaining **coinsurance**, 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 planSee 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 the Aetna Health Advocates, 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 **coinsurance** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **copayment**
2. Any remaining **deductible**
3. Then pay your **coinsurance**

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 **coinsurance** 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**, the Plan will start sharing the cost when you get **covered services**. You will continue to pay **copayments** or **coinsurance**, 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

The Aetna Health Advocates are available to answer any questions regarding the Plan. Their contact number is 1-833-361-0223

Plan features

Pre-certification covered services reduction

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

Your booklet contains a complete description of the **pre-certification** process. You will find details in the *Medical necessity and pre-certification* section.

If **pre-certification** 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**
- A \$250 benefit reduction applied separately for Maternity services

You may have to pay an additional portion of the **recognized charge** because you didn't get **pre-certification**. 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

The **deductible** must be met before the Plan pays for benefits.

Deductible type	In-network	Out-of-network
Associate only plan		
Individual	\$2,000 per year	\$4,000 per year
Family plan		
Individual	\$4,000 per year	\$8,000 per year
Family	\$4,000 per year	\$8,000 per year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives
- Outpatient and telemedicine behavioral health

Cost share waiver for risk reducing breast cancer prescription drugs

The 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%.

Cost share waiver for contraceptives (birth control)

The 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 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.

Cost share waiver for tobacco cessation prescription and OTC drugs

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.

Deductible waiver provisions for preventive prescription drugs

No **deductible** will apply to preventive covered **prescription** drug expenses:

Preventive:

Preventive drugs as defined in guidance issued by the U.S. Department of the Treasury and Internal Revenue Service (IRS) for Health Savings Accounts (HSAs) and qualified High Deductible Health Plans (HDHPs). This list will be reviewed periodically and is subject to change as federal guidelines change.

Maximum out-of-pocket limit

Includes the **deductible, copay** and **coinsurance**.

Maximum out-of-pocket type	In-network	Out-of-network
Associate only plan		
Individual	\$5,500 per year	\$10,000 per year
Family plan		
Individual	\$5,500 per year	\$10,000 per year
Family	\$11,000 per year	\$20,000 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 **coinsurance**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Family deductible

You and your covered dependents 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. The family deductible only applies to a family consisting of 3 or more eligible family members.

Copayment

This is a flat fee you pay for certain visits or **covered services**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Coinsurance

This is the percentage of the bill you pay, in most cases after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

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

The Family maximum out-of-pocket only applies to a family consisting of 3 or more eligible family members.

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**
- Amounts received from a third-party **copay** assistance program, like a manufacturer coupon or rebate, for a **specialty prescription drug**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

Your financial responsibility for the cost of **covered services** is based 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**, **coinsurance** 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	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Ambulance services

Description	In-network	Out-of-network
Emergency services	The Plan pays 90% per trip after deductible	Paid same as in-network
Non-emergency services	The Plan pays 90% per trip after deductible	Paid same as in-network

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

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	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Behavioral health

Mental health disorders 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	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Physician or behavioral health provider telemedicine consultation	The Plan pays 90% per visit after deductible	The Plan pays 65% 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: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services after you meet your deductible</p>	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Telemedicine provider mental health disorders consultation	The Plan pays 90% per visit after deductible	Not covered

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	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Physician or behavioral health provider telemedicine consultation	The Plan pays 90% per visit after deductible	The Plan pays 65% 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: <ul style="list-style-type: none"> Behavioral health services in the home Partial hospitalization treatment Intensive outpatient program <p>The cost share doesn't apply to in-network peer counseling support services after you meet your deductible</p>	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Telemedicine provider substance related disorders consultation	The Plan pays 90% per visit after deductible	Not covered

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	The Plan pays 90% per item after deductible	The Plan pays 65% per item after deductible

Emergency services

Description	In-network	Out-of-network
Emergency room	\$250 then the plan pays 90% 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. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. 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.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- If you are admitted to the **hospital** for an inpatient **stay** right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient **hospital** cost share, if any.

Foot orthotic devices

Description	In-network	Out-of-network
Orthotic devices *Includes foot orthotics, orthopedic shoes and supportive devices of the feet. Excludes foot orthotics for flat feet.	The Plan pays 90% per item after deductible	The Plan pays 65% per item after deductible

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Speech therapy (ST)

Description	In-network	Out-of-network
Speech Therapy	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Hearing aids

Description	In-network	Out-of-network
Hearing aids	The Plan pays 90% per item after deductible	The Plan pays 65% per item after deductible

Description	In-network	Out-of-network
Limit	\$3,000 per 60 months (both ears)	\$3,000 per 60 months (both ears)

Hearing exams

Description	In-network	Out-of-network
Hearing exams	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
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	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Visit limit per year	120	120
----------------------	-----	-----

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	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible

Description	In-network	Out-of-network
Outpatient services	The Plan pays 90% per visit after deductible	The Plan pays 65% 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	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission 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

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Limit per lifetime for non-surgical expenses including appliances	\$5,000	\$5,000
---	---------	---------

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – room and board	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible
Services performed in physician or specialist office or a facility	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Other services and supplies	The Plan pays 90% after deductible	The Plan pays 65% after deductible

Maternity and related newborn care important note:

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

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	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

Institutes of Quality – Cardiac Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	The Plan pays 100% per admission after deductible	The Plan pays 90% per visit after deductible	Not covered
Outpatient	The Plan pays 100% per visit after deductible	The Plan pays 90% per visit after deductible	Not covered
Pre-certification may be required			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered

Institutes of Quality – Orthopedic Surgery

Description	In network (IOQ Facility)	In network (Non-IOQ Facility)	Out-of-network
Inpatient	The Plan pays 100% per admission after deductible	The Plan pays 90% per visit after deductible	Not covered

Outpatient	The Plan pays 100% per visit after deductible	The Plan pays 90% per visit after deductible	Not covered
<i>Pre-certification may be required</i>			
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Not covered

Outpatient prescription drugs

Generic prescription drugs

Description	In-network	Out-of-network
30-day supply at a retail pharmacy	\$12 after deductible	Not covered
All refills after the two initial 30-day supply fills at a retail pharmacy	Not covered	Not covered
90-day supply at a mail order pharmacy or a CVS pharmacy	\$30 after deductible	Not covered

Value prescription drug

Description	In-network	Out-of-network
30-day supply at a retail pharmacy	\$0 after deductible	Not covered
All refills after the two initial 30-day supply fills at a retail pharmacy	Not covered	Not covered
90-day supply at a mail order pharmacy or a CVS pharmacy	\$0 after deductible	Not covered

Preferred Brand-name prescription drugs

Description	In-network	Out-of-network
30-day supply at a retail pharmacy	\$40 or 30% whichever is greater but no more than \$80 after deductible	Not covered
All refills after the two initial 30-day supply fills at a retail pharmacy	Not covered	Not covered
90-day supply at a mail order pharmacy or a CVS pharmacy	\$80 or 30% whichever is greater but no more than \$160 after deductible	Not covered

Non-preferred brand-name prescription drugs

Description	In-network	Out-of-network
30-day supply at a retail pharmacy	\$80 or 50% whichever is greater but no more than \$160 after deductible	Not covered
All refills after the two initial 30-day supply fills at a retail pharmacy	Not covered	Not covered
90-day supply at a mail order pharmacy or a CVS pharmacy	\$180 or 50% whichever is greater but no more than \$350 after deductible	Not covered

Important note:

Your cost share for **specialty prescription drugs**, under the **copayment** assistance program, will not count toward your **deductible** or **maximum out-of-pocket limit**. This includes cost shares that you, the plan or the program pay.

Anti-cancer drugs taken by mouth

Description	In-network	Out-of-network
30-day supply at a retail pharmacy	\$0 after deductible	Not covered
All refills after the two initial 30-day supply fills at a retail pharmacy	Not covered	Not covered
90-day supply at a mail order pharmacy or a CVS pharmacy	\$0 after deductible	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 after deductible	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	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of covered preventive care drugs and supplements or more information, contact the Health Advocates at 1-833-361-0223</p>	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	<p>Subject to any sex, age, medical condition, family history and frequency guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF)</p> <p>For a current list of risk reducing breast cancer drugs or more information, see the <i>Contact us</i> section</p>	Not covered

Tobacco cessation drugs

Description	In-network	Out-of-network
Tobacco cessation prescription and OTC drugs	\$0, no deductible applies	Not covered
Limits	<p>Subject to any sex, age, medical condition, family history and frequency guidelines in the recommendations of the USPSTF.</p> <p>For a current list of covered tobacco cessation drugs or more information, contact the Health Advocates at 1-833-361-0223. See the <i>Other services</i> section of this schedule for more information.</p>	Not covered

Outpatient prescription drug important note:

If a **provider** prescribes a covered **brand-name prescription drug** when a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a **provider** does not specify DAW and you request a covered **brand-name prescription drug**, you will be responsible for the cost difference between the brand-name drug and the generic drug, plus the cost share that applies to the brand-name drug.

The cost difference related to a **prescription** not specified as DAW does not apply toward your **prescription drug deductible** or **maximum out-of-pocket limit**.

Outpatient surgery

Description	In-network	Out-of-network
At hospital outpatient department	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office visit (not-surgical, not preventive)	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Physician surgical services	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Physician telemedicine consultation	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Telemedicine provider consultation	The Plan pays 90% per visit after deductible	Not covered
Basic medical services		

Description	In-network	Out-of-network
Physician visit during inpatient stay	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Specialist

Description	In-network	Out-of-network
Specialist office visit (not-surgical, not preventive)	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Specialist surgical services	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Specialist telemedicine consultation	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Description	In-network	Out-of-network
Telemedicine provider consultation Specialist services	The Plan pays 90% per visit after deductible	Not covered

All other services not shown above

Description	In-network	Out-of-network
All other services	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Preventive care

Description	In-network	Out-of-network
Preventive care services	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Breastfeeding counseling and support	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Breastfeeding 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 3 years 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 3 years 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: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Counseling for alcohol or drug misuse visit limit	5 visits/per year	5 visits/per year
Counseling for obesity, healthy diet	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per year, of which up to 10 visits may be used for healthy diet counseling.
Counseling for sexually transmitted infection	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Counseling for sexually transmitted infection visit limit	2 visits/per year	2 visits/per year
Counseling for tobacco cessation	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Counseling for tobacco cessation visit limit	8 visits/per year	8 visits/per year
Family planning services (female contraception counseling)	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% 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	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting

Immunizations	The Plan pays 100%, no deductible applies	The Plan pays 65% after deductible
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screenings	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% 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 contact the Aetna Health Advocates at 1-833-361-0223	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 contact the Aetna Health Advocates at 1-833-361-0223
Lung cancer screening	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Routine lung cancer screening limit	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening per year Screenings that exceed this limit covered as outpatient diagnostic testing
Routine physical exam	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% 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 per year after that age, up to age 22; 1 exam per year after age 22	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 per year after that age, up to age 22; 1 exam per year after age 22

	High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Well woman GYN exam limit	1 exam per year	1 exam per year

Private duty nursing

Up to eight hours equals one shift

Description	In-network	Out-of-network
Outpatient services	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Visit/shift limit per year	60	60
----------------------------	----	----

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	The Plan pays 90% per item after deductible	The Plan pays 65% 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

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	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 and occupational therapies

Description	In-network	Out-of-network
At the physician office	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
At facility that is not a hospital	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
At hospital outpatient department	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Speech therapy (ST)

Description	In-network	Out-of-network
At the physician office	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
At facility that is not a hospital	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
At hospital outpatient department	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Physical therapy

Description	In-network	Out-of-network
Visit limit per year	60	60

Occupational therapy

Description	In-network	Out-of-network
Visit limit per year	60	60

Speech therapy (ST)

Description	In-network	Out-of-network
Visit limit per year	60	60

Spinal manipulation

Description	In-network	Out-of-network
At the physician office	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Visit limit per year	12	12
----------------------	----	----

Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible
Other inpatient services and supplies	The Plan pays 90% per admission after deductible	The Plan pays 65% per admission after deductible

Day limit per year	100	100
--------------------	-----	-----

Tests, images and labs – outpatient

Diagnostic complex imaging services

Description	In-network	Out-of-network
*may require pre-certification and medical necessity review.	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network
	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	The Plan pays 90% per visit after deductible	The Plan pays 65% 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	Covered based on type of service and where it is received

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	The Plan pays 90% per visit after deductible	The Plan pays 65% 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	The Plan pays 90% per transplant after deductible	The Plan pays 65% 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	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible

Non-urgent use of an urgent care facility or provider	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
--	---	---

Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	Designated network	Non-designated network	Out-of-network
Non-emergency services	The Plan pays 100% per visit after deductible	The Plan pays 90% per visit after deductible	The Plan pays 65% per visit after deductible
Preventive care immunizations	The Plan pays 100% per visit, no deductible applies	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% 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	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician

Preventive screening and counseling services	The Plan pays 100% per visit, no deductible applies	The Plan pays 100% per visit, no deductible applies	The Plan pays 65% per visit after deductible
Preventive screening and counseling limits	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule	See the <i>Preventive care services</i> section of the schedule

Important Note:

Designated network provider

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

Non-designated network provider

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

Contact the Aetna Health Advocates at 1-833-361-0223 if you have questions.

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