Fairfax County Public Schools

Aetna/Innovation Health Plan

Preferred Provider Plan – Open POS II
Benefits Booklet

Effective January 1, 2020

Contents

Welcome

It is important to understand your benefits so you know what to do when faced with a serious illness or injury, and when you seek routine medical services. This book can help you learn about the Aetna/Innovation Health medical plan offered by Fairfax County Public Schools – what is covered and not covered, how to file a claim and how coverage coordinates with other medical plans.

This book contains information about the medical plan (referred to as the Plan) administered by Aetna/Innovation Health.

About This Book

In this book, you'll find:

- When your coverage begins and how to enroll;
- What the Plan covers and does not cover;
- Tools and resources to help you use your medical plan coverage to full advantage;
- How to file a claim or appeal a claim decision; and
- Definitions of key terms

Please read this booklet carefully and refer to it when you have questions about how your medical benefits work. You can also access one of the following resources for more information:

- **www.ih-aetna.com/fcps**;
- Benefit Resources and Tools in this booklet;
- Member Services at the number shown on your ID card (**1-888-236-6249**); or
- The FCPS Employee Benefits Handbook available at **www.fcps.edu** which has information on:
  - Who is eligible and how to enroll;
  - When coverage terminates; and
  - Continuation of coverage and leaves of absence.

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the Plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this Plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining If You Are in an Eligible Class

You are in an eligible class if:

- You are an eligible employee as defined by School Board regulations; and
- You have completed the waiting period; or
- You are an eligible retiree as defined by School Board regulations.

Determining When You Become Eligible

You become eligible for the Plan on your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this Plan, your coverage eligibility date is the effective date of the Plan.

After the Effective Date of the Plan

If you are hired after the effective date of this Plan, your eligibility coverage date is the first day of the month coinciding with or next following the date you commence active work for FCPS, or if later, the date you enter the eligible class, as determined by Fairfax County Public Schools.

If you enter an eligible class after the effective date of this Plan, your eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan, provided they meet the eligibility criteria* and you request coverage within the appropriate timeframes as specified in the FCPS Employee Benefits Handbook and/or FCPS Retiree Benefits Handbook.

*Refer to the FCPS Employee Benefits Handbook and/or FCPS Retiree Benefits Handbook for more information, including documentation that you must submit at time of enrollment to verify your spouse/dependent's eligibility.

*A child age 26 or older who is wholly dependent on the employee for support and maintenance due to a disability that occurred prior to age 26. Coverage for a disabled child may be continued past the age limits shown above. Refer to the FCPS Employee Benefits Handbook and/or FCPS Retiree Benefits Handbook for more information.

Important Reminder

Keep in mind that you cannot receive coverage under this Plan as:

Both an employee and a dependent; or

A dependent of more than one employee.

How and When to Enroll

Initial Enrollment in the Plan

You will be required to enroll in a manner determined by Fairfax County Public Schools (FCPS).

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you have a qualifying life event.

Your Effective Date of Coverage

Your coverage takes effect on the first day of the month following your date of hire/eligibility. If your date of hire/eligibility is the first day of the month, coverage will become effective on that date.

> *Important Notice:*
> You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. If requesting a change in enrollment due to a qualifying life event, your request and all supporting dependent documents must be submitted within 30 days of the event, with changes in coverage effective the first day of the month after the event (except for birth or adoption, which take effect on the date of birth or adoption). Refer to the *FCPS Employee Benefits Handbook* and/or *FCPS Retiree Benefits Handbook* for more information.

Understanding the Terms

Words and phrases that appear in **bold type** are defined in the Glossary.

> *Please Note*
> Unless noted otherwise at the beginning of a chapter, the terms "you" and "your" refer to an employee, retiree or covered participant of the Plan.

Your Plan at a Glance

Summary of Medical Benefits

This chart summarizes the benefits available under the Aetna/ Innovation Health Preferred Provider Plan, Open POS II medical plan:

Plan Feature	In-Network You Pay	Out-of-Network You Pay
Annual Deductible		
Individual	$250 per calendar year	$500 per calendar year
Family	$500 per calendar year	$1,000 per calendar year
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual	$2,000 per calendar year	$4,000 per calendar year
Family	$4,000 per calendar year	$8,000 per calendar year

Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Preventive Care * **		
Routine Physical Exam (office visit) • 1 exam per calendar year for adults and children age 18 and over	Covered in full	40% coinsurance after you meet the deductible
Well Child Visits • 1st 12 months; 7 exams • 13-24 months: 3 exams • 25-36 months: 3 exams • 3-18 years: 1 exam per calendar year	Covered in full	40% coinsurance after you meet the deductible
Preventive Screening and Counseling • obesity counseling - up to age 22: unlimited visits - age 22 and over: up to 26 visits per calendar year. Healthy diet counseling limited to 10 visits per year.	Covered in full	40% coinsurance after you meet the deductible

* For in-network services, Plan payment will not exceed the negotiated charge.
** For out-of-network charges, Plan payment is generally 60% of the recognized charge.
*** Please refer to **https://www.hhs.gov/healthcare/about-the-law/index.html#CoveredPreventiveServicesforAdults** for a full list of preventive services.

Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Preventive Screening and Counseling (cont'd) • tobacco use preventive counseling - up to 8 counseling sessions per calendar year • alcohol/drug abuse counseling: - up to 5 visits per calendar year (Also see the Behavioral Health Care section for additional benefits)	Covered in full Covered in full	40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
Female Contraceptive Counseling Contraceptive Counseling Services – Maximum Visits either in a group or individual setting *__Important Note:__ Visits in excess of the Contraceptive Counseling Services Maximum as shown above are covered under the *Physician Services* office visit section of the *Schedule of Benefits*..	Covered in full 2* visits per 12 months	40% coinsurance after you meet the deductible 2* visits per 12 months
Contraceptive Devices and Injectables *(provided and billed by your physician includes insertion/administration)* • generic devices/injectables and devices with no generic equivalent • brand-name	Covered in full $20 copay after you meet the deductible	40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible

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*** Please refer to **https://www.hhs.gov/healthcare/about-the-law/index.html#CoveredPreventiveServicesforAdults** for a full list of preventive services.

Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Routine Prostate Screening	Covered in full	40% coinsurance after you meet the deductible
Routine Colorectal Cancer Screening (average-risk members aged 45 years and older when these tests are recommended by their physician) • Colonoscopy: 1 every 10 years or • CT Colonography (virtual colonoscopy): 1 every 5 years or • Double contrast barium enema (DCBE): 1 every 5 years or • Sigmoidoscopy: 1 every 5 years or • Immunohistochemical or guaiac-based fecal occult blood testing (FOBT): every year or • Stool DNA (FIT-DNA, Cologuard): 1 every 3 years ***Important Note: Please refer to** Clinical Policy Bulletin 0516 **for additional information.**	Covered in full	40% coinsurance after you meet the deductible
Routine Annual Ob/Gyn Exam *(includes one Pap smear and related lab fees)* • 1 exam per calendar year	Covered in full	40% coinsurance after you meet the deductible
Routine Mammogram	Covered in full	40% coinsurance after you meet the deductible
Routine Lung Cancer Screening • 1 screening per calendar year, beginning at age 55	Covered in full	40% coinsurance after you meet the deductible

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*** Please refer to **https://www.hhs.gov/healthcare/about-the-law/index.html#CoveredPreventiveServicesforAdults** for a full list of preventive services.

Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Vision and Hearing		
Routine Vision Services	Covered by the Aetna Vision Preferred Plan. Refer to the Summary of Aetna Vision Preferred℠ Benefits for more information.	
Routine Hearing Exams	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Hearing Aids		
• hearing aid evaluation	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• hearing aids (adults and children)	10% coinsurance after you meet the deductible 1 per ear every 36 months; $1,500 max	40% coinsurance after you meet the deductible 1 per ear every 36 months; $1,500 max
Outpatient Care		
Office Visit: Primary Care Physician	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Office Visit: Specialist	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Allergy Testing	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Allergy Injections/Treatment *(including serum)*	$20 copay per visit after you meet the deductible. Covered in full after deductible for injections if no office visit is billed.	40% coinsurance after you meet the deductible
Outpatient Prescription Drugs (*non-self-injectable medications only)*	Drug: 10% coinsurance after you meet the deductible if shipped to home address. Covered in full after the deductible when medication is shipped for administration at your physician's office. Administration: $20 copay per visit after you meet the deductible for injection in your physician's office.	Drug: These injectable drugs must be purchased through Aetna Specialty Pharmacy Administration: 40% coinsurance after you meet the deductible for injection in your physician's office.

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Family Planning and Maternity		
Maternity Care • routine prenatal and postnatal office visits	Covered in full	40% coinsurance after you meet the deductible
• delivery (hospital charges)	After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance	After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance
Lactation Support Services *(services available during pregnancy or post-partum)* • up to 6* visits for lactation counseling services per 12 months ***Important Note:** Additional visits are covered as physician's office visits, subject to the applicable deductible, coinsurance and/or copay	Covered in full	40% coinsurance after you meet the deductible
Voluntary Sterilization • physician's office	$20 copay per visit after you meet the deductible (member deductible and copay waived for tubal ligation)	40% coinsurance after you meet the deductible
• outpatient facility	10% coinsurance after you meet the deductible (member deductible and coinsurance waived for tubal ligation)	40% coinsurance after you meet the deductible
Infertility Services	If eligible, covered services include: • diagnosis and treatment of the underlying cause of infertility • advanced reproductive technologies Infertility services are subject to a $100,000 lifetime maximum across all FCPS self-insured plans. Refer to the Clinical Policy Bulletins for more information on covered services.	
• physician's office	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• outpatient facility	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Hospital Care		
Inpatient Facility Copay	$150 per confinement	$150 per confinement
Inpatient Care *(room and board are covered up to the hospital's semi-private room rate; also includes physician services and anesthesiologist)*	After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance	After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance
Outpatient Care	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Outpatient Surgery		
Outpatient Surgery • physician's office • outpatient facility or freestanding surgical center	 $20 copay per visit after you meet the deductible 10% coinsurance after you meet the deductible	 40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
Alternatives to Inpatient Hospital Care		
Skilled Nursing Facility Care • up to a maximum of 120 days per confinement • inpatient rehabilitation up to a maximum of 90 days per confinement. Requires Utilization Management approval.	After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance. Copay waived if you transfer directly from covered inpatient care in another facility.	After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance. Copay waived if you transfer directly from covered inpatient care in another facility.
Home Health Care • up to 90 visits per calendar year	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Private Duty Nursing • up to 360 8-hour shifts per calendar year	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Hospice Care	Inpatient: After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance Alternative settings: 10% coinsurance after you meet the deductible	Inpatient: After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance Alternative settings: 40% coinsurance after you meet the deductible

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Emergency and Urgent Care		
Emergency Room		
• emergency care	$150 copay per visit, then 10% coinsurance for all services after you meet the deductible Copay waived if admitted	$150 copay per visit, then 10% coinsurance for all services after you meet the deductible Copay waived if admitted
• non-emergency care	Not covered	Not covered
Urgent Care		
• urgent care center	10% coinsurance after you meet the deductible	10% coinsurance after you meet the deductible
Telemedicine (Teladoc)	$20 copay per session after you meet the deductible	Covered through Teladoc only.
Walk-In Clinic	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Ambulance		
• emergency use/medically necessary transport	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
• non-clinical/not medically necessary use	Not covered	Not covered
Other Covered Expenses		
Chiropractic Care (Coverage dependent on periodic review for medical necessity.)	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Complex Imaging *(includes MRI, PET scan, and CT scan)*	$75 copay after you meet the deductible	40% coinsurance after you meet the deductible
Diagnostic X-Ray and Lab Tests		
• billed with physician's office visit	Included with office visit copayment (deductible applies)	40% coinsurance after you meet the deductible
• outpatient hospital or freestanding facility	Covered in full after you meet the deductible	40% coinsurance after you meet the deductible
Durable Medical Equipment	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Habilitation Therapy Services – Autism Spectrum Disorder (physical, occupational, speech)		
• office visit No visit limitations	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Habilitation Therapy Services – Diagnosis other than Autism Spectrum Disorder (physical, occupational, speech) Up to 90 visits per calendar year for physical therapy; up to 90 visits per year for occupational therapy; up to 90 visits per year for speech therapy.		
• office visit	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Short-Term Rehabilitation *(physical, occupational, speech)* Up to 90 visits per calendar year for physical therapy; up to 90 visits per year for occupational therapy; up to 90 visits per year for speech therapy. (Aetna will review periodically to determine appropriateness.)		
• Office visit	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• Outpatient hospital or facility	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Behavioral Health Care (precertification may be required – please refer to the Precertification section)		
Mental Health Treatment		
• inpatient	After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance	After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance
• outpatient office visit	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• outpatient facility	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Substance Abuse Treatment		
• inpatient	After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance	After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance
• outpatient office visit	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• outpatient facility	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible

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Summary of Aetna Vision Preferred℠ Benefits

This chart summarizes the optional vision benefits available through Aetna Vision Preferred:

	Network	Out-of-Network *Maximum Plan Benefit*
Service Frequencies:		
Comprehensive Exam	Every Calendar Year	
Lenses (including contacts lenses)[1]	Every Calendar Year	
Frames	Every 2 Calendar Years	
Routine/Comprehensive Eye Exam Benefit	$20 Copay	Up to $40 Reimbursement
Exam Options:		
Standard Contact Lens Fit and Follow-Up	Member Pays discounted fee of $40	Not Covered
Premium Contact Lens Fit and Follow-Up	Member pays 90% of retail	Not Covered
Frames Any available frame at provider location, including frames for prescription sunglasses	$130 Plan Allowance. Member pays 80% of balance over $130 Plan Allowance	Up to $45 Reimbursement
Standard Plastic Lenses		
Single Vision	$0 Copay	Up to $40 Reimbursement
Bifocal	$0 Copay	Up to $60 Reimbursement
Trifocal	$0 Copay	Up to $80 Reimbursement
Lenticular	$0 Copay	Up to $80 Reimbursement
Standard Progressive Lens	$65 Copay	Up to $60 Reimbursement
Premium Progressive Lens[2]	Member pays 80% of Charge plus $65 copay less $120 allowance	Up to $60 Reimbursement
Lens Options:		
UV Treatment	Member Pays $15	Not Covered
Tint (Solid and Gradient)	Member Pays $15	Not Covered
Standard Plastic Scratch Coating	$0 Copay	Up to $5 Reimbursement
Standard Polycarbonate - Adults	$0 Copay	Up to $5 Reimbursement
Standard Polycarbonate - Kids under 19	$0 Copay	Up to $5 Reimbursement
Standard Anti-Reflective Coating	Member Pays $45	Not Covered
Polarized	Member Pays 80% of Retail	Not Covered
Other Add-Ons	Member Pays 80% of Retail	Not Covered
Contact Lenses *(Contact lens reimbursement includes materials only)*		
Conventional	$125 Plan Allowance. Member pays 85% of balance over $125 Allowance	Up to $125 Reimbursement
Disposable	$125 Plan Allowance. Member pays 100% of balance over $125 Allowance	Up to $125 Reimbursement
Medically Necessary	$0 Copay	Up to $200 Reimbursement
Laser Vision Correction Lasik or PRK from U.S. Laser Network[3] only	15% off retail price or 5% off promotional price	Not Covered

[1] During each benefit period the plan allows for EITHER lenses or contacts.

[2] Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions.

[3] Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Benefit Resources and Tools

Resources

When you have questions or need more information, here are some of the resources available to you.

Resource	Situation	How to Contact
Aetna/Innovation Health	Contact Member Services when: • You have questions about the Plan's medical benefits • You are required to obtain preauthorization for a service from an out-of-network provider (precertification) • You have a question about a claim	Phone: **1-888-236-6249** Online: Log in to your secure member website at **www.aetna.com** to chat online; or e-mail with Member Services at **www.ih-aetna.com/fcps**
Your Secure Member Website	Use your member website when you need: • Eligibility or claim status information • A replacement ID card • Copies of claim forms • Access to tools that help you manage your health care	Online: **www.aetna.com**
CVS Caremark **(FCPS Pharmacy Vendor)**	Contact CVS Caremark Customer Care when: • You have questions about the Plan's prescription drug benefits • You have a question about a prescription drug claim	Phone: **1-888-217-4161** Online: **http://info.caremark.com/fcps**

Fairfax County Public Schools Department of Human Resources	Contact the Department of Human Resources when: • You have questions about how to elect or change coverage • You have a qualifying life event or status change	HR Connection Phone: **(571)423-3000** **1-800-831-4331** Online: **www.fcps.edu** Employees > Benefits E-mail: HRConnection@FCPS.edu
Fairfax County Public Schools Office of Payroll Management	Contact the Office of Payroll Management when: • You need to report a change in your name • Submit changes to your address or telephone number	Phone: **(571) 423-3500** Online: **www.fcps.edu** Employees > Payroll Information E-mail: Payroll.Help@FCPS.edu Submit address/telephone changes through UConnect online at: **http://www.fcps.edu/hr/technology/uconnect.shtml**

Tools

Online Provider Directory

The online provider directory gives you the most recent information on the doctors, hospitals and other providers in the network. For each doctor or other health care provider, you can learn about his or her credentials and practice, including education, board certification, languages spoken, office location and hours, and parking and handicapped access. You can also provide feedback on a primary care physician (PCP), specialist or other medical professional after receiving services, using the online survey available.

To access the online provider directory, go to **www.ih-aetna.com/fcps** and select Find a Doctor from the Medical dropdown menu.

Health Information Website

Use your secure member website at **www.aetna.com** as your online resource for personalized benefit and health information. Once registered, you'll have access to secure, personalized features, such as benefit and claim status, as well as specific health and wellness information:

- Print eligibility information;
- Request a replacement ID card;
- Download copies of claim forms;
- Check the status of a claim;
- View Explanations of Benefits; and
- Contact Member Services.

You also have 24/7 access to useful tools that help you manage your health care, including:

- *Cost of Care*, a tool that allows you to research the costs of office visits, medical tests and selected medical procedures in your area.
- *Hospital Comparison Tool*, a tool that helps you compare area hospitals on measures that are important to your health.
- *Simple Steps To A Healthier Life®*, an online wellness program that offers information and self-help tools for weight loss, stress management and fitness. When you visit the program's site, you can complete a Health Risk Assessment and receive a personalized action plan with recommended healthy living programs based on your personal health needs.

Clinical Policy Bulletins

Clinical Policy Bulletins (CPBs) are guidelines used by Aetna/Innovation Health when making benefit and claim decisions. CPBs are written on selected health care topics, such as infertility, new technologies and new treatment approaches and procedures. The CPBs describe a service or supply has been determined to be medically **necessary**, based on clinical information.

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

Keep in Mind

The CPBs define whether a service or supply is medically **necessary**, but they do not define whether the service or supply is covered by the Plan. This book, along with other Plan documents, describes what is covered and what is not covered by the Plan.

If you have questions about your coverage, you can contact Member Services at the toll-free telephone number on your ID card.

How the Plan Works

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

The Plan pays benefits only for medically **necessary** services and supplies.

This section describes important features of the Plan. To learn how these features apply to the Plan, refer to the Summary of Benefits.

The Provider Network

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

Doctors, hospitals and other health care providers that belong to the network are called in-network providers. The providers in the network represent a wide range of services, including:

- Primary care (general and family practitioners, pediatricians and internists);
- Specialty care (such as Ob/Gyns, surgeons, cardiologists and urologists); and
- Health care facilities (such as hospitals, skilled nursing facilities and diagnostic testing labs).

When they join the network, providers agree to provide services or supplies at **negotiated charges**.

To find an in-network provider in your area:

- *Use* the online provider directory. Connect to the directory from **http://www.ih-aetna.com/fcps** by selecting Find a Doctor from the Medical dropdown menu. Register and follow the prompts to select the type of search you want, the area in which you want to search and the number of miles you're willing to travel. You can search the online **directory** for a specific doctor, type of doctor or all the doctors in a given zip code and/or travel distance.
- *Call Member Services*. Member Services representatives can help you find an in-network provider in your area. You can also request a printed listing of in-network providers in your area without charge. The Member Services' toll-free number is printed on your ID card.

Primary Care

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

It's Your Choice

When you need medical care, you have a choice. You can select a doctor or facility that belongs to the network (an in-network provider) or one that does not belong (an out-of-network provider).

- *If you use an in-network provider*, you'll pay less out of your own pocket for your care. You won't have to fill out claim forms, because your in-network provider will file claims for you. In addition, your provider will make the necessary telephone call to start the precertification process when you must be hospitalized or need certain types of care.
- *If you use an out-of-network provider,* you'll pay more out of your own pocket for your care. You may be required to file your own claims and you must make the telephone call required for precertification. You are also responsible for paying all charges in excess of the recognized charge. In some cases, these amounts could be significant.

The Summary of Benefits shows how the Plan's level of coverage differs when you use in-network versus out-of-network providers. In most cases, you save money when you use in-network providers.

Key Terms

The following key terms are the foundation of the Plan:

Negotiated Charge

In-network providers have agreed to charge no more than the negotiated charge for a service or supply that is covered by the Plan. You are not responsible for amounts that exceed the negotiated charge when you obtain care from a network provider.

Non-Occupational Coverage

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

Recognized Charge

The Plan pays out-of-network benefits only for the part of a covered expense that is recognized.

> *Keep in Mind*
>
> If your out-of-network provider charges more than the **recognized charge**, you will be responsible for any expenses incurred that are above the recognized charge. In some cases, these amounts could be significant. You are highly encouraged to contact Member Services prior to having services performed by an out-of-network provider to discuss the benefit amounts to be paid.

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

Sharing the Cost of Care

You share in the cost of your medical care by paying deductibles, copays and **coinsurance**. These terms are explained below.

Deductible

The **deductible** is the part of covered expenses you pay each calendar year before the Plan starts to pay. There are separate calendar year deductibles for in-network and out-of-network benefits and for individual and family coverage:

- *Individual*: The individual deductible applies separately to each covered person in the family. When a person's deductible expenses reach the individual deductible shown in the Summary of Benefits, the person's deductible is met. The Plan then starts to pay benefits for that person at the appropriate coinsurance percentage, after any applicable copay.
- *Family*: The family deductible applies to the family (or mini family) as a group. When each individual in a mini family reaches their individual deductible, the family deductible is met or when the combined deductible expenses of all covered family members reach the family deductible shown in the Summary of Benefits, the family deductible is met. The Plan then begins to pay benefits for all covered family members.

Keep in Mind

Amounts above the recognized charge do not count toward your annual deductible.

Copay (copayment)

A **copay**, sometimes called a copayment, is the specific dollar amount that you must pay up-front for some types of care. The Plan includes copayments that are specified in the Summary of Benefits. A copay applies once your deductible has been met.

Please note that when you are admitted to a hospital or treatment facility or use your emergency room benefits, you pay the first part of your covered expenses as a deductible and then a copay. The inpatient facility copay applies to each admission, except for admissions made within 60 days of another admission. Once you have met your deductible and paid the copay, you and the Plan share the cost of covered care through coinsurance. See Coinsurance for more information.

Coinsurance

The portion paid by the Plan, shown in the Summary of Benefits, is the Plan's coinsurance. When the Plan's coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

The Plan has different coinsurance levels for in-network and out-of-network care for each type of covered expense. Refer to the Summary of Benefits charts for more information.

Out-of-Pocket Maximum

The Plan puts a limit on the amount you pay for coinsurance, copays and deductibles each year, called the **out-of-pocket maximum**.

There are separate calendar year out-of-pocket maximums for in-network and out-of-network benefits and for individual and family coverage:

- *Individual*: The individual out-of-pocket maximum applies separately to each covered person in the family. When a person reaches the individual out-of-pocket maximum shown below the Plan pays 100% of that person's covered medical expenses for the rest of the calendar year.
- *Family*: The family out-of-pocket maximum applies to the family (or mini family) as a group. When each individual in a mini family reaches the individual out-of-pocket maximum, the Plan pays 100% of covered medical expenses for the individual for the rest of the calendar year, or when the combined expenses of all family members satisfy the family out-of-pocket maximum, the Plan pays 100% of the family's covered medical charges for the remainder of the calendar year.

Your out of pocket maximum is listed below:

Out-of Pocket Maximum	In-Network	Out-of-Network
Medical Plan: deductible, copay and coinsurance out-of-pocket maximum	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family

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

- Expenses over the recognized charge.
- Your out-of-pocket expenses (such as copays and coinsurance) for services covered by the Aetna Vision Preferred program.
- Charges for services and supplies that are not covered by the Plan.

Precertification

Precertification is a process that helps you and your **physician** determine whether the services being recommended are covered expenses under the Plan.

Precertification starts with a telephone call to Member Services:

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

When You Must Precertify Care

If using an **out-of-network provider**, you or your provider are required to call to precertify for the services in the following chart to assure that your care will be covered by the Plan.

Type of Service	When You Need to Precertify Out-of-Network Care
Hospital Inpatient Care You or your out-of-network provider must request precertification for inpatient confinement in an out-of-network hospital	To request precertification, call Member Services at **1-800-236-6249** as follows: • emergency admission: within 48 hours of admission or as soon as reasonably possible • urgent admission: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission
Alternatives to Hospital Inpatient Care You or your out-of-network provider must request precertification for the following hospital alternatives if your provider is not in the network: • **skilled nursing facility** care • home health care services • **hospice care** – inpatient and outpatient • private duty nursing	To request precertification, call Member Services at **1-800-236-6249** as follows: • inpatient confinements: same as hospital inpatient care (above) • outpatient care: - non-emergency care – at least 14 calendar days in advance or as soon as reasonably possible - emergency care – as soon as reasonably possible
Inpatient Behavioral Health Care You or your out-of-network provider must request precertification for inpatient confinement in an out-of-network hospital or treatment facility.	To request precertification, call Aetna Behavioral Health at **1-800-424-4047** as follows: • emergency admission: within 48 hours of admission or as soon as reasonably possible • urgent admission: before you are scheduled to be admitted • other admissions: at least 14 calendar days prior to admission
Outpatient Behavioral Health Care You or your out-of-network provider must request precertification for these services if your provider is not in the network: • psychological testing • neuropsychological testing • outpatient ECT • biofeedback • detoxification	To request precertification, call Aetna Behavioral Health at **1-800-424-4047**

Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days must be certified. You, your physician or the facility should call Aetna at the number on your ID card no later than the

final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a copy of this determination letter.

Keep in Mind

Certain types of care, such as bariatric or transplant surgery, must be reviewed by Aetna in advance to ensure the care is medically necessary and will be covered by the Plan. The chart below shows you the services that must be precertified, whether they'll be done on an inpatient or outpatient basis.

Services and Supplies That Require Precertification

Precertification is required for the following types of medical expenses. This list is periodically updated. For a full list of services and supplies that require precertification, please contact Member Services at **1-800-236-6249**.

Inpatient and Outpatient Care	
• advanced reproductive technology (ART) services • bariatric surgery (obesity) • cardiac implantable devices • comprehensive infertility services • cosmetic and reconstructive surgery • diagnostic cardiology • injectable drugs (immunoglobins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications) • kidney dialysis • knee surgery • Non-emergency or elective transport between facilities	• nuclear cardiology • outpatient back surgery not performed in a physician's office • private duty nursing • radiation oncology therapy • sleep studies • stays in a hospice facility • stays in a hospital • stays in a rehabilitation facility • stays in a treatment facility for treatment of mental disorders and substance abuse • stays in a skilled nursing facility • transplants • wrist surgery

If You Don't Precertify

If you don't precertify the services listed, claims may not be paid if determination is made that your care (or the setting where the care is to be provided) is not considered medically necessary. Thus, you or your out-of-network provider must call to be sure your care will be covered.

Precertification of Behavioral Health Care

Precertification is required for inpatient mental health and substance abuse treatment. When you need behavioral health care, contact Aetna Behavioral Health at **1-800-424-4047**. A behavioral health coordinator will confidentially evaluate your situation and refer you to a **behavioral health provider** who is suited to your needs.

You must contact Aetna Behavioral Health for certain outpatient therapy services (refer to the chart in When You Must Precertify Care), and you may access their services for assistance finding a behavioral health provider.

In an Emergency

You have coverage 24 hours a day, 7 days a week, anywhere in the world, if care is needed to treat an **emergency condition**.

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

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

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

Keep in Mind

If you are not sure whether a health concern is of an emergency nature, you may also check with your doctor or call the Informed Health Line at **1-800-556-1555**.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

FCPS Group Health Plans' Commitment to Privacy

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Effective Date: April 14, 2003 | Amended Date: April 18, 2005 | July 13, 2012 / May 21, 2013 / September 9, 2013 / February 25, 2015

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Fairfax County Public Schools (FCPS) Group Health Plan (the "Plan" or "we") is committed to protecting the privacy of your "protected health information (PHI)." Protected health information, referred to as "medical information" in this Notice, is information that identifies you and relates to your physical or mental health or to the provision or payment of health services for you. ,We create, receive and maintain your medical information when the Plan provides health benefits to you and your covered dependents. We are required to provide you with certain rights related to your medical information.

We have the following legal obligations under federal health privacy law — the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the related regulations to:

- Maintain the privacy of your medical information
- Provide you with this Notice of our legal duties and privacy practices with respect to your medical information
- Abide by the terms of this Notice currently in effect

This Notice becomes effective as of the effective date of your health coverage and will remain in effect unless and until we publish a revised Notice.

Who Will Follow This Notice

This Notice discusses the practices of the Plan regarding your medical information and the standards to which it will hold any third parties (such as health insurance companies) that assist in the administration of the Plan.

Information Subject to This Notice

This notice of Privacy Practices applies to FCPS' Health Plans covered by HIPAA regulations, for example, health benefits plans, dental plans, vision plan, pharmacy benefit programs, and flexible medical spending account, collectively the "Plan." We, as the Plan, create, receive and maintain certain medical information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. We obtain this medical information from applications and other forms that you may complete, through conversations you may have with our benefits administrative staff and health care professionals, and from reports and data provided to us by health care service providers, insurance companies and other third parties.

The medical information we have about you includes, among other things, your name, address, phone number, birth date, Social Security number and health claims information. This is the information that is subject to the privacy practices described in this Notice. This Notice does not apply to medical information created, received or maintained by FCPS on behalf of the non-

health employee benefits that it sponsors, including disability benefits and life insurance benefits. This Notice also does not apply to medical information that FCPS requests, receives and maintains about you for employment purposes, such as employment testing or determination of your eligibility for medical leave benefits or disability accommodations.

Summary of the Plan's Privacy Policies

The Plan's Uses and Disclosures of Your Medical Information

Generally, you must provide a written authorization to us in order for us to use or disclose your medical information. However, we may use and disclose your medical information without your authorization for administering the Plan and for processing claims. We also may disclose your medical information without your authorization for other purposes as permitted by the federal health privacy law, such as health and safety, law enforcement or emergency purposes. The law also requires us to disclose medical information when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

Your Federal Rights Under HIPAA Regarding Your Medical Information

Under 45 CFR Parts 160 and 164, (Standards for Privacy of Individually Identifiable Health Information) you have several rights regarding medical information. You have the right to:

- Inspect, access, and/or copy your medical information
- Request that your medical information be amended
- Request an accounting of certain disclosures of your medical information
- Request certain restrictions related to the use and disclosure of your health information
- Request to receive your medical information through alternative means or location for receiving confidential communications
- Request an electronic copy of your electronic medical records
- Request restriction of information sharing regarding services you pay for yourself
- Receive notification upon a breach of your unsecured Protected Health Information
- File a complaint with the Plan or the secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated or a breach has occurred
- Receive a paper copy of this Notice

Contact Information

If you have any questions or concerns about the Plan's privacy practices or about this Notice or if you want to obtain additional information about the Plan's privacy practices, contact:

HIPAA Compliance Officer
Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: **(571) 423-3065** or **1-877-702-5137**
Fax: **(571) 423-5058**

Detailed Notice of the Plan's Privacy Practices

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.

How the Plan May Use and Disclose Health Information About You

Except as described in this section, as provided for by federal health privacy law, or as you have otherwise authorized, we only use or disclose your health information for administering the Plan and processing health claims. The uses and disclosures that do not require your authorization are described below with specific examples of such disclosures.

Please note that most of the medical information about you will be handled by the insurance companies and business associates that administer the Plan, not the FCPS Office of Benefits Services. Occasionally, however, the Office of Benefits Services will receive or maintain such information. The Plan's contracts with these insurance companies require them to protect the privacy of your medical information. The purpose of this Notice is to advise you about how the Plan and the business associates that work for the Plan may use that information.

For Treatment

We are not aware of any circumstances under which FCPS will be providing treatment information about you to health care providers. In the event that such inquiries are made, however, we may use or disclose medical information about you to facilitate medical treatment or services by providers. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment

We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan or to coordinate your coverage. Our business associates may confer with your health care provider to determine whether a particular treatment is medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or with another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose medical information about you to run the Plan efficiently and in the best interests of all its participants. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating and other activities relating to Plan coverage; or conducting or arranging for medical reviews, legal services, audit services, and the fraud and abuse detection program.

Disclosures to Health Plan Sponsor

We do not disclose your medical information to the Plan Sponsor (FCPS). We may share de-identified aggregate information with the Plan Sponsor for plan administration purposes including, but not limited to quality assurance, monitoring or auditing functions. FCPS will not use your medical information for non-Plan purposes or for purposes not covered by this Notice, such as employment decisions.

Disclosures to Business Associates

We may disclose certain medical information, without your authorization, to our "business associates." Business associates are third parties that assist us in the Plan's operations, such as insurance companies. For example, we may share your claims information with business associates that provide claims processing services to the Plan, and we may disclose your medical information to our business associates for actuarial and audit purposes and legal services. We enter into contracts with these business associates to ensure that they protect the privacy of your medical information.

As Required by Law: Lawsuits and Disputes

We may disclose medical information about you when required to do so by federal, state, or local law and by related judicial and administrative proceedings. For example, we may disclose your medical information in response to a subpoena, discovery request, court or administrative order, or other legal process.

Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. We also may disclose your health information for public health activities such as preventing or controlling disease, injury, or disability; reporting births and deaths; or reporting child abuse or neglect.

Emergency Situations

We may use or disclose your medical information to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.

Others Involved in Your Care

In limited circumstances, we may use or disclose your medical information to a family member, close personal friend or others whom we have verified are involved in your care or payment for your care. For example, your medical information may be disclosed if you are seriously injured and unable to discuss your case with us. Also, in certain circumstances, we may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death.

Personal Representatives

Your medical information may be disclosed to people whom you have authorized to act on your behalf or to people who have a relationship with you that gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have power of attorney for adults.

Treatment and Health-Related Benefits Information

Our business associates and we may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and education.

Research

We do not use your medical information for research purposes.

Organ and Tissue Donation

If you are an organ donor, we may use or disclose your medical information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.

Deceased Individuals

The medical information of a deceased individual may be disclosed to coroners, medical examiners and funeral directors so that those professionals can perform their duties.

Military and Veterans

If you are a member of the armed forces or a veteran, we may release medical information about you in order to comply with laws and regulations related to military service or veterans' affairs. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We do not release your medical information for workers' compensation program without your authorization.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure.

Data Breach Notification Purposes

We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Law Enforcement

- To help law enforcement officials in their law enforcement duties.
- To respond to a court order, subpoena, warrant, summons, or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- To provide information about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
- To provide information about a death that may be the result of criminal conduct.

- To provide information about criminal conduct on FCPS property.
- In emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, protection of public officials and other national security activities authorized by law.

Genetic Information Nondiscrimination Act (GINA)

We do not use or disclose genetic information for underwriting purposes or for any other reason.

Other Uses and Disclosures for Fundraising and Marketing Purposes

We do not use your medical information for fund-raising and marketing purposes.

Any Other Uses and Disclosures Require Your Express Written Authorization

Uses and disclosures of your medical information other than those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, we will not disclose the medical information covered by the revoked authorization except to the extent the Plan has already relied on your authorization. You also should understand that insurance laws might affect your ability to revoke your authorization.

Once your medical information has been disclosed pursuant to your authorization, the federal health privacy protections may no longer apply to the disclosed medical information, and that information may be redisclosed by the recipient without your or our knowledge or authorization.

Your Federal Rights Under HIPAA Regarding Your Medical Information

Under 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information), you have several rights regarding medical information that the Plan creates, receives and maintains about you. You should address such requests to exercise your rights to:

HIPAA Compliance Officer
Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: **(571) 423-3065** or **1-877-702-5137**
Fax: **(571) 423-5058**

Your Individual Rights

You have the following individual rights regarding medical information we maintain about you:

Right to Access

You have the right to request healthcare records. This right is not absolute. You have the right to obtain and review a copy of your protected health information in the Plan's or its Business Associates designated record set that may be used to make decisions about your Plan benefits. You must submit your request in writing to the Compliance Officer at the address above. If you request a copy of the information, we may charge a fee for the costs of copying and mailing that information.

We may deny your request to inspect and copy that health information in certain very limited circumstances, such as certain psychotherapy notes and information compiled for certain legal proceedings. If you are denied access to health information, we will inform you in writing, and in certain circumstances you may request that the denial be reviewed.

Right to Your Medical Records

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you may request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format your request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable fee for the labor associated with transmitting the electronic medical record.

Right to Request That Your Medical Information Be Amended

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Compliance Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan.
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the information that you would be permitted to inspect or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" made by the Plan or its Business Associates. An accounting of disclosures is a list of disclosures of your medical information that we have made. The maximum accounting period is six years. The accounting that the Plan or its Business Associates provide will not include disclosures made before April 14, 2003; disclosures made for treatment, payment or health care operations; disclosures made earlier than six years before the date of your request; and disclosures made to you or pursuant to your written request. The accounting will tell you the person to whom your medical information was disclosed, the date of the disclosure, a description of the information disclosed and the purpose of the disclosure.

To request an accounting of disclosures, you must submit your request in writing to the Compliance Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accountings. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. We are under no obligation to agree to requests for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Compliance Officer. You must include with your request: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse). We will notify you in writing as to whether we agree to your request for restrictions.

Right to Request a Restriction for Services Paid Out-of-Pocket

You have the right to request a restriction to share information about your treatment for services you pay for yourself.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain confidential way or at specific or certain agreed upon location. For example, you can ask that we contact you only at work or by mail.

To request confidential communications by alternative means or at an alternative location, you must make your request in writing to the Compliance Officer. Your request should state the reason(s) for your request and the alternative means by which or the location at which you would like to receive your health information. If you believe that the disclosure of all or part of your health information by non-confidential communications could endanger you, your request should state that. The Plan will accommodate reasonable requests and notify you appropriately.

Right to Receive Notice of a Breach

You have the right to be notified of a breach of any of your unsecured Protected Health Information.

Rights About Fundraising Communication

We do not use or disclosure your Protected Health Information for marketing and fundraising purposes. You have the right to opt out of fundraising communications, and your Protected Health Information cannot be sold without your permission.

Right to a Paper Copy of the Privacy Notice

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time upon request. even if you agree to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this notice by mail, you should contact the Department of Human Resources, Office of Equity and Compliance at the below address. You may also obtain an electronic copy of this notice at the Plan's website.

HIPAA Compliance Officer
Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: **(571) 423-3065** or **1-877-702-5137**
Fax: **(571) 423-5058**

Changes to this Notice

We reserve the right to change any of the privacy policies and related practices at any time, as allowed by federal and state law, and to make the change effective for all information that we maintain. The terms of the revised Notice may apply to medical information we already have about you as well as any information we receive in the future. If we materially change any of the privacy practices covered by this Notice, we will provide you with the revisions within 60 days and post the revised Notice on the Plan's website.

We will post a copy of the current Notice on the Plan's website at **www.fcps.edu**. That Notice will contain the effective date on the top right-hand corner. You should monitor the website for revisions. Copies of the revised Notice will be made available to you upon your written request.

Your Right to File a Complaint and Contact Information

The Plan provides a process as required by HIPAA for you to make complaints regarding the Plan's policies and procedures or compliance with policies and procedures related to protecting the privacy of your health information. If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer or with the Secretary of the Department of Health and Human Services. To file a complaint, you must submit it in writing to the following:

HIPAA Compliance Officer
Fairfax County Public Schools
Department of Human Resources
Office of Equity & Employee Relations
8115 Gatehouse Road, Suite 2500
Falls Church, VA 22042
Phone: **(571) 423-3065** or **1-877-702-5137**
Fax: **(571) 423-5058**

Office for Civil Rights
U.S. Department of Health & Human Services
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
Phone: **(215) 861-4441**; **(215) 861-4440** (TDD)
Fax: **(215) 861-4431**

What the Medical Plan Covers

In this section, you'll find more detailed information about the services and supplies covered by the Plan. It's important to remember that the Plan covers only services and supplies that are **necessary** to diagnose or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The Plan pays benefits for covered expenses only. The benefit level for each type of covered expense is shown in the Summary of Benefits.

Some expenses are not covered by the Plan. Examples of expenses not covered are listed in this section and also in the section titled What the Plan Does Not Cover.

Preventive Care

The Plan's coverage of preventive care includes:

Routine Physical Exams

The Plan covers charges for routine physical exams, subject to the copay/coinsurance described in the Summary of Benefits. Included as part of the exam are:

- X-rays, laboratory services and other tests given in connection with the exam.
- Immunizations for infectious diseases and the materials needed to administer the immunizations.
- Testing for tuberculosis.

The exam must be given by a physician or under the direction of a physician.

If an exam is given to diagnose or treat a suspected or identified injury or disease, it is ***not*** considered a routine physical exam.

The Summary of Benefits shows how often the Plan will pay benefits for a routine physical exam.

> *Keep in Mind*
> The Plan does not pay benefits for school or employment-related exams, or for those needed to take part in school athletic programs.

What Is Not Covered as Part of a Routine Physical Exam

Medicines, drugs, appliances, equipment or supplies
Immunizations required solely for travel or employment
Psychiatric, psychological, personality, or emotional testing or exams
Premarital exams

Screening and Counseling Services

The Plan covers charges, subject to the copay/coinsurance levels described in the Summary of Benefits, made by your primary care physician for the following in an individual or group setting:

- Obesity: screening and counseling services to help you lose weight if you are obese. Coverage includes:
  - Preventive counseling visits;
  - Nutritional counseling; and
  - Healthy diet counseling visits for those with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease.
- Use of tobacco products: screening and counseling services to help you stop using tobacco products. A tobacco product is a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes:
  - Preventive counseling visits;
  - Treatment visits; and
  - Class visits.
- Misuse of alcohol and/or drugs: screening and counseling services to help prevent or reduce the use of alcohol or controlled substances. Coverage includes:
  - Preventive counseling visits;
  - Risk factor reduction intervention; and
  - A structured assessment.

Some screening and counseling services are subject to the visit/frequency maximums shown in the Summary of Benefits.

> *Note*
> Refer to the Behavioral Health Care section for a description of covered mental health and substance abuse treatment.

Routine Cancer Screenings

The Plan covers routine cancer screenings, subject to the copay/coinsurance described in the Summary of Benefits. These screenings include:

- Routine mammograms for women.
- Digital rectal exam (DRE) and prostate specific antigen (PSA) tests for men age 40 and over.
- Beginning at age 55, one preventive screening for lung cancer each year if you have a history of smoking.

Beginning at age 45, the Plan covers the following tests when recommended by your physician:

- For those at average risk for colorectal cancer:

– Annual Immunohistochemical or guaiac-based fecal occult blood testing (FOBT)
– One colonoscopy every 10 years; or
– One CT Colonography (virtual colonoscopy) every 5 years; or
– One sigmoidoscopy every 5 years; or
– One double contrast barium enema every 5 years; or
– One Stool DNA (FIT-DNA, Cologuard) every 3 years

***Important Note: Please refer to** Clinical Policy Bulletin 0516 **for additional information.**

–

Routine Ob/Gyn Exams

The Plan covers one annual routine ob/gyn exam, including one Pap smear and related laboratory fees. The exam is subject to the copay/coinsurance described in the Summary of Benefits.

Important Notes:

The recommendations and guidelines of the:

Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; **http://www.cdc.gov/vaccines/acip/**

United States Preventive Services Task Force; **http://www.uspreventiveservicestaskforce.org**

Health Resources and Services Administration; **http://www.hrsa.gov/**

American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents

Information referenced throughout this *Preventive Care* section may be updated periodically. This Plan is subject to updated recommendations or guidelines that are issued by these organizations beginning on the first day of the plan year, one year after the recommendation or guideline is issued.

Refer to the Summary of Benefits for information about cost-sharing and maximums that apply to preventive care benefits.

Vision and Hearing Services

Routine Eye Exams

Routine eye exams are covered by the Aetna Vision Preferred program. Refer to Aetna Vision Preferred for more information.

Routine Hearing Exams

Subject to the copay/coinsurance described in the Summary of Benefits, the Plan covers charges for an audiometric hearing exam when the exam is performed by:

- An otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association; and
  - Performs the exam at the written direction of an otolaryngologist or otologist.

The Plan does not cover:

- Any hearing device or service that does not meet professionally acceptable standards;
- Hearing exams given during your stay in a hospital or other facility; or
- Any tests, appliances and devices to:
  - Improve hearing, including amplifiers;
  - Enhance other forms of communication to compensate for hearing loss; or
  - Simulate speech.

Office Visits and Walk-In Clinics

Office Visits

The Plan covers treatment by a doctor in his or her office. Refer to the Summary of Benefits chart for details.

Coverage includes:

- Allergy testing and treatment;
- Immunizations for infectious disease; and
- Supplies, radiology services, X-rays and tests given by the physician.

> *Keep in Mind*
> The Plan does not cover immunizations that are needed only for travel or employment.

Walk-In Clinics

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

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

Family Planning and Maternity

Voluntary Sterilization

The Plan covers charges made by a **physician** or **hospital** for a vasectomy or tubal ligation. Refer to the Summary of Benefits chart for coverage details. The Plan does ***not*** cover the reversal of a sterilization procedure.

Infertility Services

The Plan covers three levels of **infertility** services:

- Basic
- Comprehensive
- Advanced reproductive technology (ART) services

> *Please Note*
> You can find more detailed information about covered and excluded services in the Coverage Policy Bulletins (CPBs) available at **www.aetna.com**.

Basic Infertility Care

The Plan covers diagnosis of the underlying medical cause of infertility and treatment of the underlying medical cause of infertility, subject to coverage guidelines in the medical policy.

Eligibility for Comprehensive Infertility and ART Services

You are eligible for comprehensive infertility and ART services if:

- You are covered under this Plan as an employee or as the legal spouse of a covered employee.
- There exists a condition that:
  - Is demonstrated to cause the disease of infertility**.**
  - Has been recognized by your physician or infertility specialist and documented in your medical records.
- You have not had a voluntary sterilization (tubal ligation, tubal occlusion or vasectomy) with or without surgical reversal, regardless of post reversal results.
- You do not have infertility that is due to a natural physiologic process such as age-related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the criteria determined by Aetna.

Infertility services must be approved in advance and coordinated by Aetna's National Infertility Unit (NIU). The NIU's team of registered nurses and infertility coordinators will:

- Evaluate your medical records to determine whether the proposed infertility services are reasonably likely to result in success; and
- Determine whether the proposed infertility services are eligible for coverage by the Plan.

To begin the process, you or your provider must call the NIU at **1-800-575-5999** to enroll in the infertility program and obtain the required precertification.

Comprehensive Infertility Services

The Plan covers the following, when approved in advance by Aetna's National Infertility Unit (NIU) and performed by a network provider:

- Ovulation induction cycles with menotropins; and
- Intrauterine insemination.

Advanced Reproductive Technologies

If the basic and comprehensive infertility services do not result in a pregnancy, the Plan covers the following advanced reproductive technology (ART) services, up to the maximums shown in the Summary of Benefits. Services must be performed on an outpatient basis and approved in advance by the NIU:

- Any combination of the following ART services:
  - In vitro fertilization (IVF);
  - Zygote intrafallopian transfer (ZIFT);
  - Gamete intrafallopian transfer (GIFT); and
  - Cryopreserved embryo transfers.
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. Covered services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Services to obtain a spouse's sperm when the spouse is covered by the Plan.

Remember!

Call Member Services before you receive the services listed above. They will refer you to the NIU.

Infertility Service Limits

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

- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of a sterilization procedure;
- Purchase of donor sperm, donor eggs, or donor embryos;
- Obtaining sperm from a male who is not covered by the Plan;
- Storage of eggs, sperm or embryos;
- Care of the donor required for donor egg retrievals or transfers;

- Cryopreservation or storage of cryopreserved eggs, sperm, embryos or reproductive tissues;
- Thawing of cryopreserved eggs, sperm or embryos;
- All charges associated with gestational carrier (surrogate parenting) programs, for either the covered person or the gestational carrier;
- Home ovulation prediction kits or home pregnancy kits;
- Infertility services for covered females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle, or who manifest a positive Clomid challenge;
- Infertility services that are not reasonably likely to be successful;
- Self-injectable medications (visit **http://info.caremark.com/fcps** for the Formulary Drug List);
- Comprehensive and ART services provided by an out-of-network provider, unless approved in advance by the NIU; or
- Services received by a spouse or partner who is not covered by the Plan.

Maternity Care

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

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

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

Precertification is not required for the first 48 hours of hospital confinement after a vaginal delivery or 96 hours after a cesarean delivery. Any days of confinement over these limits must be precertified. You, your doctor or another health care provider can request precertification by calling the number on your ID card.

➞ ***Remember!*** You must add your newborn child within **30 calendar days** of the date of birth in order for the baby to be covered. Refer to the FCPS Employee Benefits Handbook for more information.

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

Birthing Center

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

Breast Feeding Support and Supplies

The Plan covers:

- Initial purchase of a standard (not hospital-grade) electric breast pump or manual breast pump during pregnancy or while breast feeding.
- Purchase of the accessories needed to operate the breast pump.
- For each subsequent pregnancy:
  - Purchase of a replacement manual breast pump.
  - Purchase of a replacement standard electric breast pump, if:
    - you have not purchased a standard electric pump within the past three years; or
    - the initial electric pump is broken or out of warranty.
  - Purchase of a new set of breast pump supplies.

Comprehensive Lactation Support and Counseling Services

The Plan includes comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. The "post-partum period" means the 60 day-one-year period directly following the child's date of birth.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Summary of Benefits.

Hospital Care

Inpatient Hospital Care

The Plan covers charges made by a **hospital** for **room and board** when you are confined as an inpatient. Room and board charges are covered up to the hospital's **semi-private room rate**.

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

- Ambulance transfer services when the service is owned or contracted by the hospital;
- Physician and surgeon services;
- Operating and recovery rooms;
- Intensive or special care facilities;
- Administration of blood and blood products, but not the cost of the blood or blood product;
- Radiation therapy;
- Physical, occupational and speech therapy;
- Cardiac and pulmonary rehabilitation;
- Oxygen and oxygen therapy;
- X-rays, laboratory tests and diagnostic services;
- Medications;
- Intravenous (IV) preparations; and

- Discharge planning.

Keep in Mind

The Plan does not cover private room charges that exceed the hospital's semi-private room rate unless a private room is medically **necessary** because of a contagious illness or immune system problems.

If a hospital does not itemize room and board charges, as well as other charges, Aetna will assume that 40 percent of the total is for room and board and 60 percent is for other charges.

Some physicians and other providers may bill you separately for services given during your hospital stay. If you receive services from a surgical assistant, radiologist, anesthesiologist or pathologist who is not in the Aetna network (an out-of-network provider) during an inpatient stay at an in-network facility, the Plan will cover those services at the in-network benefit level.
(Contact Member Services if you receive a balance bill from an out-of-network provider who provided services during your inpatient stay at an in-network facility.)

Outpatient Hospital Care

The Plan covers charges made by a hospital for services and supplies provided on an outpatient basis.

Pre-Admission Testing

The Plan covers outpatient pre-admission testing done prior to a covered surgical procedure by a hospital, surgery center, physician or licensed diagnostic lab if the tests:

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

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

Keep in Mind

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

Surgery

The Plan covers the charges made by a physician for:

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

Keep in Mind

If you have multiple surgical procedures done at the same time or during a single operating session, the Plan normally pays a lower percentage of the fees that are charged for the secondary procedure(s).
The Plan does ***not*** cover any surgery that is not medically necessary, even if performed with another procedure that is necessary.

Pre-operative and post-operative visits by your surgeon are considered to be part of the surgical fee. The Plan does ***not*** cover separate fees for pre-operative and post-operative care.

Surgery performed by a physician who is not in the Aetna/Innovation Health network will be covered as out-of-network care and subject to recognized charge limits . . . even if the surgery is performed in an in-network hospital.

Anesthesia

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

Acupuncture

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

Oral Surgery

The Plan covers treatment of accidental injury to natural teeth and oral surgery that is considered medical-in-nature.

Medical or Dental?

Oral surgery that is medical-in-nature is typically covered by a medical plan. It involves:

Disease of the facial bones

Trauma to the soft and hard tissue structures of the face and oral cavity

Correcting facial deformities present at birth or later

Surgery that is dental-in-nature involves the teeth. Tooth surgery is typically covered by a dental plan.

The Plan covers:

- Hospital services and supplies received for an inpatient hospital confinement required because of your condition.
- Services of a physician or **dentist** for treatment of the following conditions of the teeth, mouth, jaws, jaw joints or supporting tissues if medically necessary:
  - Surgery necessary to treat a fracture, dislocation or wound;
  - Surgery necessary to alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot improve function;
  - Surgery necessary to cut out cysts, tumors or other diseased tissues;
  - Surgery to cut into gums and tissues of the mouth, as long as this is not done in connection with the removal, replacement or repair of teeth; and

  - Non-surgical treatment of infections or diseases not related to the teeth.
- Treatment of accidental injury to sound natural teeth or tissues of the mouth. The treatment must occur within the calendar year of the accident, or in the following calendar year. The teeth must have been free from decay or in good repair, and firmly attached to the jaw bone at the time of the injury.
  The Plan's coverage of dentures, bridgework, crowns and appliances is limited to:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown (cap) needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Except as described above to treat accidental injury, the Plan does ***not*** cover charges:

- For dental-in-nature oral surgery expenses;
- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of those services or supplies is to relieve pain;
- For root canal therapy;
- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace or restore fillings, crowns, dentures or bridgework;
- For dental cleaning, in-mouth scaling, planing or scraping; or
- For myofunctional therapy. This is muscle training therapy or training to correct or control harmful habits.

Dental Plan Coverage
If you are also covered under the Aetna Dental Plan, refer to **www.ih-aetna.com/fcps** for more information on dental plan coverage.

Outpatient Surgery

The Plan covers outpatient surgery in:

- The office-based surgical facility of a **physician** or **dentist** (for covered dental procedures that are medical in nature);
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery is covered only if it:

- Can be performed adequately and safely only in a surgery center or hospital; and
- Is not normally performed in a physician's or dental office (in the event of a medical-in-nature procedure that is normally performed in a dental office).

The Plan covers the following outpatient surgery expenses:

- Services and supplies provided by the hospital, surgery center or office-based surgical facility on the day of the procedure;

- The operating physician's services for performing the procedure, related pre- and post-operative care, and the administration of anesthesia; and
- Services of another physician for related post-operative care and the administration of anesthesia (other than a local anesthetic).

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

Keep in Mind

If you receive services from a surgical assistant, radiologist, anesthesiologist or pathologist who is not in the Aetna/Innovation Health network (an out-of-network provider) in connection with your outpatient surgery performed by an in-network physician, the Plan will cover those services at the in-network benefit level. Call Member Services at the number on your ID card with any questions you may have about your bill.
(Contact Member Services if you receive a balance bill from an out-of-network provider who provided services during your inpatient stay at an in-network facility.)

Reconstructive Surgery

The Plan covers reconstructive surgery if the surgery is needed:

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

Transgender Reassignment Surgery

The Plan covers medically necessary gender reassignment (sometimes called sex change) surgery.

Coverage includes:

- The surgical procedure;
- Physician pre-operative and post-operative hospital and office visits;
- Inpatient and outpatient services (including outpatient surgery);
- Administration of anesthetics;
- Outpatient diagnostic testing, lab work and radiological services; and

- Blood transfusions and the cost of unreplaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled.

The Plan does ***not*** cover cosmetic procedures associated with gender reassignment.

To Learn More

Refer to the Clinical Policy Bulletins for more information about covered services.

Transplants

If You Need a Transplant

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

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

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

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

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

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

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

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

The Plan covers:

- Evaluation.
- Compatibility testing of prospective organ donors who are immediate family members.

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

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

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

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

Refer to Special Programs for more information about the National Medical Excellence Program.

The Institutes of Excellence™ Network

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

The amount you will pay for covered transplant services is determined by the type of service, place of service, and the network status of your providers. See the Summary of Benefits beginning on page 4 for details on how various services are covered. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- Any other in-network facility

- An out-of-network facility

Transplant services are covered at both in and out-of-network facilities, but your cost share may be lower when you receive services from an in-network facility (including IOE facilities). All transplant services, including out-of-network care, must be precertified by Aetna.

Christian Science

The Plan covers care from a Christian Science Practitioner when you are admitted to a sanatorium for healing, not rest or study. A sanatorium must be operated by or listed and certified based on the criteria established by the First Church of Christ Science in Boston to be recognized as a hospital.

Alternatives to Hospital Inpatient Care

Skilled Nursing Facility

The Plan covers charges made by a **skilled nursing facility** during an inpatient stay, up to the maximum shown in the Summary of Benefits, including:

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

Keep in Mind
Skilled nursing facility coverage does not include treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness.

Home Health Care

The Plan covers home health care services when ordered by a **physician** and given to you under a **home health care plan** while you are homebound. Coverage includes:

- Part-time nursing care that requires the medical training of, and is given by, an RN or by an LPN if an RN is not available. The services must be provided during intermittent visits of four hours or less.
- Part-time home health aide services, when provided in conjunction with, and in direct support of, care by an RN or LPN. The services must be provided during intermittent visits of four hours or less.
- Medical social services by a qualified social worker, when provided in conjunction with, and in direct support of, care by an RN or LPN.
- Medical supplies, prescription drugs and lab services given by (or for) a **home health care agency**. Coverage is limited to what would have been covered if you had remained in a hospital.

Keep in Mind

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

The Plan does not cover care that isn't part of a home health care plan.

Hospice Care

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

The Plan covers **hospice care** for a person who is **terminally ill**.

The Plan covers:

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

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

- Private or special nursing services.
- Funeral arrangements.

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

Private Duty Nursing

The Plan covers charges made by a Registered Nurse (**RN**) or Licensed Practical Nurse (**LPN**) for private duty nursing if a person's condition requires **skilled nursing services** and visiting nursing care is not enough.

The Plan pays benefits up to the maximum shown in the Summary of Benefits. A shift consists of up to 8 hours of skilled nursing care.

The Plan also covers skilled observation following:

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

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

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

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

Emergency and Urgent Care

Emergency Care

The Plan covers **emergency care** provided in a hospital emergency room or a free-standing emergency facility. The care must be for an emergency condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;

- Hospital nursing staff services; and
- Radiology and pathology services.

Keep in Mind
The Plan does not cover non-emergency care given in a hospital emergency room.

Refer to the Summary of Benefits for copayment/coinsurance information.

Emergency Care
This means the treatment given to you in a hospital's emergency room to evaluate and treat medical conditions of recent onset and severity – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

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

Urgent Care

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

The urgent care benefit covers:

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

Telemedicine

The Plan provides telemedicine services for minor health issues through Teladoc. Teladoc offers you phone or video consults as an alternative to costly urgent care and ER visits when you need care immediately.

Examples of services provided include: Cold and flu symptoms, allergies, bronchitis, urinary tract infection, respiratory infection and sinus issues.

For more information or to utilize the services:

- **www.teladoc.com/aetna**
- **1-855-Teladoc (835-2362)**

Ambulance

The Plan covers charges made for ambulance services, subject to the coinsurance level listed in the Summary of Benefits**.** The conditions for coverage vary with the type of vehicle used.

Ground Ambulance

The Plan covers:

- Transportation in a medical emergency to the first hospital where treatment is given;
- Transportation in a medical emergency from one hospital to another hospital when the first hospital does not have the required services or facilities for your condition;
- The plan will only cover ambulance services (ground or air) to the nearest appropriate medical facility that is able to provide the care that you need. In some cases you may be able to get limited, medically necessary, non-emergency ambulance transportation if all of the following apply:
  - Such transportation is needed to obtain treatment or diagnose your health condition
  - The use of other transportation could endanger your health.

Air or Water Ambulance

In a medical emergency, transport by air or water ambulance from one hospital to another hospital is covered if:

- The first hospital does not have the required services or facilities for your condition; and

Ground ambulance is not medically appropriate because of the distance, or your condition is unstable and requires medical supervision and rapid transport.

Note: Elective transportation including facility to facility transfer requires pre-approval from the Plan.

Other Covered Expenses

This section describes other covered expenses for both inpatient and outpatient care. The Plan's standard level of benefits applies to these expenses, unless shown otherwise in the Summary of Benefits.

Autism Spectrum Disorders

The Plan covers charges for the diagnosis and treatment of Autism Spectrum Disorder.

Autism Spectrum Disorder means any pervasive developmental disorder, including:

- Autistic Disorder;
- Asperger's Syndrome;
- Rett's Syndrome;
- Childhood Disintegrative Disorder; or
- Pervasive Developmental Disorder – Not Otherwise Specified.

Treatment must be identified in a treatment plan and prescribed and determined medically necessary by a licensed physician or licensed psychologist. Covered care includes:

- *Behavioral health treatment* – professional counseling and guidance services and treatment plans to develop, maintain or restore function to the maximum extent practicable;
- *Psychiatric care* – consultative services of a psychiatrist licensed in the state in which s/he practices;
- *Psychological care* – direct or consultative services provided by a psychologist licensed in the state in which s/he practices;
- *Therapeutic care* – services provided by licensed or certified speech, occupational or physical therapists, or clinical social workers;
- *Applied behavioral analysis* when approved by or supervised by a board-certified behavior analyst licensed by the Board of Medicine.

Applied behavioral analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis of the relationship between the environment and behavior.

Chemotherapy

The Plan provides coverage for chemotherapy. In most cases, chemotherapy is covered as outpatient care.

The Plan covers the initial dose of chemotherapy given in the hospital when:

- You have been hospitalized for the diagnosis of cancer; and
- A hospital stay is necessary based on your health status.

Chiropractic Care (Spinal Manipulation)

The Plan covers manipulative treatment of a condition caused by (or related to) biomechanical or nerve conduction disorders of the spine. Care must be given by a physician or licensed chiropractor in the provider's office.

Treatment should follow a specific plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Clinical trial therapies (experimental or investigational)

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

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

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

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status.

This requirement does not apply to procedures and treatments that do not require FDA approval.

- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs)

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

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

Diabetic Equipment, Supplies and Education

The Plan covers the following services used in the treatment if insulin and non-insulin dependent diabetes and gestational diabetes:

- In-person outpatient self-management training and educational services, including medical nutrition therapy; and
- Diabetic services and supplies.

Diagnostic Complex Imaging

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

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

Reminder

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

Diagnostic X-Ray and Laboratory (DXL) Procedures

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

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

Durable Medical and Surgical Equipment

The Plan covers the rental of durable medical and surgical equipment, up to the limits shown in the Summary of Benefits. Examples include wheelchairs, crutches, hospital beds and oxygen for home use. The Plan covers only one item for the same (or a similar) purpose, plus the accessories needed to operate the item.

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

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

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

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

Refer to Aetna's Clinical Policy Bulletins for more information on covered services.

Habilitation Therapy Services

Habilitation therapy services are services that 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).

Eligible health services include habilitation therapy services your physician prescribes. The services have to be performed by:

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

Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.

- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.

- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.

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

Hearing Aids

The Plan covers hearing aids, including fitting and repair for adults and children. The benefit is limited to 1 hearing aid per ear every 36 months to a maximum of $1,500 per ear.

Infusion Therapy

Infusion therapy is the intravenous or continuous administration of medications or solutions as part of your treatment. The Plan covers infusion therapy given on an outpatient basis by:

- A free-standing clinic;
- The outpatient department of a hospital; or
- A physician/nurse in his/her office or in your home.

Coverage includes the following services and supplies:

- The pharmaceutical administered;
- Any medical supplies, equipment, and nursing services needed to support the therapy;
- Total parenteral nutrition;
- Enteral nutrition
- Chemotherapy;
- Drug therapy, including antibiotics and antivirals;
- Pain management; and
- Hydration therapy, including fluids, electrolytes and other additives.

Limits

The Plan does not cover the following as infusion therapy:

- Blood transfusions and blood products;
- Dialysis (dialysis is not covered as infusion therapy but is covered for renal failure); or
- Insulin.

Medical Foods

The Plan covers medical foods considered necessary for the dietary treatment of **inherited metabolic disease** when prescribed by a physician and used under continued strict medical supervision.

Medical foods are specially manufactured formulas and products that are not generally available in supermarkets or grocery stores but obtained directly from a manufacturer.

The Plan does not cover:

- Over-the counter items or supplements that are available without a prescription;
- Conventional food items that are naturally low in protein, even if otherwise consumed by patients with inherited metabolic disease;
- Food supplements, as they are not generally intended for treatment of inherited metabolic disorders; or
- Convenience items such as recipe books.

Outpatient Radiology Services

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

Outpatient Short-Term Rehabilitation

Physical, Occupational and Speech Therapy

The Plan covers outpatient short-term rehabilitation services, as described below, when prescribed by a physician. The services must be performed by:

- A licensed or certified physical, occupational or speech therapist; or a practitioner certified by the Behavior Analyst Certifying Board (BACB);
- A hospital;
- A home health care agency; or
- A physician.

The Plan covers:

- Cognitive therapy associated with physical rehabilitation when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- Physical therapy (except for services provided in an educational or training setting), provided that the therapy is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation, employment counseling and services provided in an educational or training setting), provided that the therapy is expected to:
  - significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure; or
  - help the patient relearn skills that significantly improve independence in the activities of daily living.
- Speech therapy (except for services provided in an educational or training setting, or to teach sign language), provided that the therapy is expected to:

- significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure; or
- improve delays in speech function development as a result of 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.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services provided in your home if you are homebound.

Inpatient Therapy
Inpatient rehabilitation benefits for the services listed will be paid as part of your inpatient hospital and skilled nursing facility benefits.

The Plan limits benefits for rehabilitative physical, occupational and speech therapy to the maximums shown in the Summary of Benefits.

Prosthetic Devices

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

Here are some examples of covered devices:

- An artificial arm, leg, hip, knee or eye;
- An eye lens in connection with cataract surgery;
- An external breast prosthesis and the first bra made solely for use with the prosthesis after a mastectomy;
- Custom foot orthotics and other supportive devices of the feet (in accordance with Aetna's medical policy);
- A breast implant after a mastectomy; and
- A cardiac pacemaker.

Coverage includes:

- Purchase of the first prosthesis that you need to temporarily or permanently replace an internal body part or organ, or an external body part.
- Instruction and incidental supplies needed to use a covered prosthetic device.
- Replacement of a prosthetic device if:
  - The replacement is needed because of a change in your physical condition or because of normal growth or wear and tear;
  - Replacement is likely to cost less than repairing the existing device; or

– The existing device cannot be made serviceable.

Pulmonary and Cardiac Rehabilitation

The Plan covers:

- Outpatient cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The services must be part of a treatment plan based on your risk level and recommended by your physician. The Plan covers up to 36 sessions in a 12-week period.
- Outpatient pulmonary rehabilitation to treat reversible pulmonary disease. The Plan covers up to 36 hours or a six-week period of therapy.

Radiation Therapy

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

Women's Health Provisions

Federal law affects how certain health conditions are covered by the Plan. Your rights under these laws are described here.

The Newborns' and Mothers' Health Protection Act

Maternity hospital stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:

- The level of benefits for any portion of the hospital stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plan cannot require precertification for a stay of up to 48 or 96 hours, as described above.

The Women's Health and Cancer Rights Act

When a woman who is covered by the Plan decides to have reconstructive surgery after a medically necessary mastectomy, the Women's Health and Cancer Rights Act requires the Plan to cover these procedures:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical (balanced) appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

This coverage will be provided in consultation with the attending physician and the patient.

For answers to questions about the Plan's coverage of mastectomies and reconstructive surgery, call Member Services at the number on your ID card.

Behavioral Health Care

The Plan includes coverage for behavioral health care. You receive a higher level of benefits for inpatient and outpatient treatment of **mental disorders** and **substance abuse** that is given by a **behavioral health provider** in the Aetna Behavioral Health network. Out-of-network care is covered, too, but at a lower level of benefits. Refer to the Summary of Benefits for a comparison of in-network and out-of-network behavioral health care benefits.

Inpatient Care

The Plan covers inpatient services in a **hospital**, **psychiatric hospital** or **treatment facility** when Aetna Behavioral Health determines your condition requires services that are available only in an inpatient setting. Coverage includes:

- **Room and board charges**, up to the facility's **semi-private room rate**; and
- Other necessary services and supplies.

Services should be preauthorized by Aetna Behavioral Health.

> *Note*
> Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna Behavioral Health. Refer to the Precertification section for more information about the process and requirements for precertifying inpatient stays and certain services.

Partial Confinement

The Plan covers charges for **partial confinement treatment** or partial hospitalization services provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder or substance abuse. The charges will be covered as outpatient care.

Care is covered when preauthorized and only if the condition requires treatment that is available only in a partial confinement treatment setting or if you would need inpatient care if you were not participating in this type of program.

Outpatient Treatment

The Plan also covers the effective treatment of mental disorders or substance abuse on an outpatient basis.

Limits

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

- Administrative psychiatric services when these are the only services rendered.
- Bereavement counseling.
- Confrontation therapy.
- Consultations with a mental health professional for adjudication of marital, child support and custody cases.
- Court-mandated or legally mandated treatment that is not considered **necessary**, as determined by Aetna, or that would not otherwise be covered by the Plan.

- Ecological or environmental medicine, diagnosis or treatment.
- Educational evaluation/remediation therapy or school consultations.
- Erhard Seminar Training (EST) or similar motivational services.
- Expressive therapies (art, poetry, movement, psychodrama).
- Hypnosis and hypnotherapy.
- Lovaas therapy.
- Marriage, family, child, career, social adjustment, religious, pastoral or financial counseling, except for covered members with a diagnosed behavioral disorder.
- Mental and psychoneurotic disorders not listed in the International Classification of Diseases, Ninth Revision (ICD-9).
- Mental health treatment for weight reduction or control.
- Primal therapy.
- Psychodrama.
- Stand-by services required by a physician.
- Telephone consultations.
- Transcendental meditation.
- Therapies for the following diagnoses, because they are considered both developmental and/or chronic in nature:
  - Down syndrome.
  - Cerebral palsy.
- Treatment of antisocial personality disorder.
- Treatment of impulse control disorders such as:
  - Caffeine or nicotine use;
  - Kleptomania;
  - Pathological gambling; or
  - Pedophilia.
- Treatment of health care providers who specialize in mental health and receive treatment as part of their training in that field.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment for someone who is mentally incapacitated.
- Treatment of sexual addiction, co-dependency or any other behavior that does not have a DSM-IV diagnosis.
- Wilderness programs.

Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 applies to the mental health and substance abuse services provided under the Plan. The act requires mental health and substance use disorder benefits to have parity with medical and surgical benefits. Treatment limitations (such as the number of visits or days of coverage) and financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket expenses) that apply to mental health and substance abuse benefits must be no more restrictive than the most frequent or common medical and surgical limitations and requirements. The act also mandates parity for out-of-network coverage. Plans that cover out-of-network medical or surgical treatments must provide comparable coverage for out-of-network mental health and substance abuse benefits.

What the Plan Does Not Cover

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

General Exclusions

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

- For cancelled or missed appointments.
- For care, treatment, services or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider's license.
- For care, treatment, services or supplies not prescribed, recommended or approved by a physician or dentist.
- For claim form completion.
- For drugs, devices, treatments or procedures that are **experimental or investigational**, except as described in What the Medical Plan Covers.
- For services and supplies Aetna determines are not **necessary** for the diagnosis, care or treatment of the disease or injury involved – even if they are prescribed, recommended or approved by a physician or dentist.
- For services given by volunteers or persons who do not normally charge for their services.
- For services and supplies provided as part of treatment or care that is not covered by the Plan.
- For services and supplies provided in school or camp infirmaries.
- For services of a resident physician or intern.
- For services, supplies, medical care or treatment given by members of your immediate family (your spouse, child, stepchild, brother, sister, in-law, parent or grandparent) or your household.
- Incurred before the date coverage starts or after the date coverage ends.
- In excess of the **recognized charge** for a service or supply given by an **out-of-network provider**.
- In excess of the **negotiated charge** for a given service or supply given by an **in-network provider**.

- Made only because you have health coverage or that you are not legally obligated to pay, such as:
  - Care in charitable institutions; or
  - Care in a hospital or other facility that is owned or operated by any government, except to the extent coverage is required by law.
- Related to employment or self-employment. This includes injuries that arise out of (or in the course of) any work for pay or profit, unless there is no other source of coverage or reimbursement available to you.
- To have preferred access to a physician's services, such as boutique or concierge physician practices.

Alternative Health Care

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

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

Biological and Bionic

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

- The services of blood donors, apheresis or plasmapheresis.

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

- Growth hormones, surgical procedures or any other treatment, device, drug, service or supply used solely to increase or decrease height or alter the rate of growth.

Cosmetic Procedures

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

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

Custodial and Protective Care

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

- Any item or service that is primarily for the personal comfort and convenience of you or a third party.
- Care provided to create an environment that protects a person against exposure that can make his or her disease or injury worse.
- Care, services and supplies provided in a:
  - Rest home;
  - Assisted living facility;
  - Health resort, spa or sanitarium; or
  - Similar institution serving as an individual's primary residence or providing primarily custodial or rest care.
- **Custodial care** – care provided to help a person in the activities of daily life.
- Maintenance care.
- Removal from your home, work place or other environment of potential sources of allergy or illness, including:
  - Asbestos or fiberglass;
  - Carpeting;
  - Dust, pet dander or pests;
  - Mold; or
  - Paint.

Dental Care

Except for care necessary to repair teeth damaged directly as a result of accidental injury, the medical Plan does ***not*** cover services, treatment or supplies related to the care, filling, removal or replacement of teeth, including:

- Apicoectomy (dental root resection), root canal therapy, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty.
- Application of fluoride and other substances to protect, clean or alter the appearance of teeth.

- Dental implants, false teeth, plates, dentures, braces, mouth guards or other devices to protect, replace or reposition teeth.
- Non-surgical treatments to alter bite or the alignment or operation of the jaw, including:
  - Treatment of malocclusion; and
  - Devices to alter bite or alignment.

Note
If you are also covered under the Aetna Dental Plan, refer to **www.ih-aetna.com/fcps** for more information on dental plan coverage.

Education and Training

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

- Services or supplies related to education, training, retraining services or testing, including:
  - Special education;
  - Remedial education;
  - Job training; or
  - Job hardening programs.
- Services, treatment, and education testing or training related to behavioral (conduct) problems, learning disabilities and delays in developing skills. This exclusion does not apply to applied behavioral analysis for treatment of Autism Spectrum Disorders.

Family Planning and Maternity

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

- Home births.
- Home uterine activity monitoring.
- Over-the-counter contraceptive supplies, including (but not limited to) condoms and contraceptive foams, jellies and ointments.
- Reversal of sterilization procedures.

Foot Care

Except as described in Diabetic Equipment, Supplies and Education, the Plan does ***not*** cover services, supplies or devices to improve the comfort or appearance of toes, feet or ankles, including:

- Shoes, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments, or other supplies, even when required after treatment of an illness or injury that was covered by the Plan.
- Non-custom orthotics, arch supports, shoe inserts and other devices to support the feet.

- Treatment of calluses, toenails, hammertoes, subluxations, fallen arches, weak feet or chronic foot pain.
- Treatment for conditions caused by routine activities such as walking, running, working or wearing shoes.

Government and Armed Forces

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

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

Under any government law. Health Exams

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

- By any government law.
- By a third party, including exams to obtain or maintain employment, or which an employer must provide under a labor agreement.
- To obtain professional or other licenses.
- To obtain insurance.
- To travel; attend a school, camp or sporting event; or participate in a sport or other recreational activity.

Home and Mobility

The Plan does not cover alterations or additions to your home, work place or other environment, or any related equipment or device, including (but not limited to):

- Bathroom equipment such as tub seats, benches, rails and lifts.
- Equipment or supplies to help you sit or sleep, such as electric beds, water beds, air beds, warming or cooling devices, elevating chairs and reclining chairs.
- Exercise and training devices, whirlpools, sauna baths, massage devices or over-bed tables.
- Purchase or rental of air purifiers, air conditioners, water purifiers or swimming pools.
- Room additions or changes to countertops, doorways, lighting, wiring or furniture.
- Stair glides, wheelchair ramps and elevators.

The Plan does not cover vehicles and transportation devices, or alterations to any vehicle or transportation device, including:

- Automobiles, vans or trucks.
- Bicycles.
- Stair-climbing wheelchairs.

- Personal transporters.

Prescription Drugs

The medical Plan covers prescription drugs provided while you are a hospital inpatient. The Plan does ***not*** cover:

- Any prescription drug you obtain on an outpatient basis (except non-self-injectable drugs provided by Aetna Specialty Pharmacy).
- Any prescription drug obtained illegally outside of the U.S., even if covered when purchased in the U.S.
- Drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- Immunizations related to travel or work.
- Injectable drugs, if an oral alternative is available.
- Needles, syringes and other injectable aids, except as covered for diabetic supplies.
- Over-the-counter drugs, biologicals or chemical preparations that can be obtained without a prescription.
- Performance-enhancing steroids.
- Self-injectable drugs.
- Services related to the dispensing, injection or application of a drug.
- Treatment, drug, service or supply to:
  - Stop or reduce smoking or the use of other tobacco products; or
  - Treat or reduce nicotine addiction, dependence or cravings.

  This exclusion includes (but is not limited to) counseling, hypnosis, medications, patches and gum.

Note

Injectable drugs that must be administered by a medical professional in an office setting are covered under the medical Plan. These injectables must be purchased through Aetna Specialty Pharmacy. The Plan's deductible and coinsurance apply as shown in the Summary of Benefits, but there is no separate copay for the drug (although a copay may apply to a physician's services or an office visit for administration).

Self-administered injectable prescription drugs obtained on an outpatient basis are covered under the pharmacy plan administered by your FCPS pharmacy vendor.

Reproductive and Sexual Health

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

- Drugs to treat erectile dysfunction, impotence, or sexual dysfunction or inadequacy, whether delivered in oral, injectable or topical forms. Refer to your FCPS pharmacy benefits to determine prescription drug coverage available.
- Therapy, supplies or counseling for sexual dysfunction or inadequacies with no physiological or organic basis.
- Treatment, drugs, services or supplies to treat sexual dysfunction, enhance sexual performance or enhance sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sexual organ; and
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Short Term Rehabilitation Services and Habilitation Services

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy

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

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

Outpatient Speech Therapy

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

- Any services unless provided in accordance with a specific treatment plan;
- Speech therapy services provided during a stay in a hospital, skilled nursing facility or hospice stay (as these inpatient expenses would be considered under the hospital, skilled nursing facility or hospice benefits);
- Services provided by a home health care agency;
- Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
- Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; and
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Strength and Performance

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

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

Tests and Therapies

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

- Full-body CAT scans.

Hair analysis.

- Hyperbaric therapy, except to treat decompression or promote healing of a wound.
- Sleep therapy.

Vision

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

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

Note

Aetna Vision Preferred offers you access to a national network of participating providers for discounts on exams and a wide variety of eyewear and lenses. Some vision-related expenses that are excluded from medical plan coverage may be covered by the Aetna Vision Preferred Plan.

Aetna Vision Preferred

Your Plan provides benefits for routine eye care as well as limited coverage of eyeglass frames, lenses or contact lenses.

You have the freedom to choose any vision care provider when you need services. How that care is covered and how much you pay out of your pocket depend on whether you choose an **in-network provider** or **out-of-network provider**.

The Plan covers contact lens fitting exams and follow-ups as well as contact lenses or eyeglasses and frames. Contact lens and fitting exams must be by a qualified ophthalmologist or optometrist.

The benefit level for each type of covered expense is shown in the Summary of Benefits.

What the Vision Plan Covers

Lenses and Frames

The Plan covers eyeglasses, contact lenses and frames. Eyeglass lenses, or contact lenses, are covered every calendar year. Frames are covered once every two years.

Lenses

The Plan covers the following prescription eyeglass lenses:

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

The Plan also offers coverage or discounts for the following lens options:

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

Refer to the Summary of Benefits for more information about allowances, copayments, coinsurance and discounts.

Frames

The Plan covers any available frame, including frames for prescription sunglasses, when purchased with covered prescription lenses. Refer to the Summary of Benefits for more information.

Contact Lenses

The Plan covers prescription contact lenses required to correct visual acuity. Coverage includes fittings and conventional and disposable contact lenses. Refer to the Summary of Benefits for more information.

Note: Fittings for extended/overnight wear lenses are considered premium, not standard, contact lens fittings.

What the Vision Plan Does Not Cover

The Plan does not cover every vision care service or supply, even if prescribed, recommended or approved by your provider.

The following exclusions apply to vision benefits:

- Any charges in excess of the benefit, dollar or supply limits show in the Summary of Benefits.
- Charges for services or supplies provided by a network provider in excess of the **negotiated charge**.
- Charges rendered to any person who is not eligible for coverage.
- Any exams given during your stay in a hospital or other facility for medical care.
- Drugs or medicines.

  Note: Medically necessary drugs and medicines may be covered by the FCPS pharmacy benefit plan.

- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

  Note: While the surgery is not covered, discounts may be available for certain services. Also, cataract surgery may be covered under the medical Plan.

- Lenses and frames furnished or ordered before the date the person becomes covered.
- Payment for the portion of the charge that another party is the primary payer.
- Prescription sunglasses or light sensitive lenses in excess of the amount that would be covered for non-tinted lenses.
- Replacement of lost, stolen or broken prescription lenses or frames.
- Special supplies such as subnormal vision aids.
- Special vision procedures, such as orthoptics, vision therapy or vision training.
- Vision services that are covered in whole or in part:
  - Under any other plan of group benefits provided by the Fairfax County Public Schools; or
  - Under any workers' compensation law or any other law of like purpose.
- Vision services or supplies that do not meet professionally accepted standards.

Special Programs

The value-added discount and health management programs described in this section support a healthy lifestyle and provide resources in the event of a serious illness.

Health Management Programs

Online Health Assessment

Simple Steps to a Healthier Life® can help you be your healthiest. This personalized online health and wellness program offers resources to help you eat better, lose weight, get in shape, relieve stress and more.

Start the program by taking an online *health assessment* to help you identify your health needs. The health assessment (HA) questionnaire asks you about your general health and well-being. It is easy to complete in about 15-20 minutes.

> *Earn a Wellness Incentive!*
>
> Take the health assessment **between January 1, 2020 and December 31, 2020**, and you may be eligible for a $100 wellness incentive. The wellness credit will be applied to unmet future deductible and/or coinsurance amounts for you or covered members of your family. The wellness incentive is available to primary cardholders only.

After you complete the health assessment, you'll get a snapshot of your current health status and a wellness score, so you can become familiar with potential health risks and receive strategies to help reduce them. Your personalized *action plan* will recommend online programs and interactive tools in areas such as nutrition, fitness, stress relief and smoking cessation – chosen for you based on your health needs. Your individualized *health report* may also include information on how to obtain health coaching and/or receive other health or wellness programs that are offered through Aetna/Innovation Health.

Tailor the program to meet your needs and lifestyle by choosing the resources that are right for you. To get started, log in to your secure member website at **www.aetna.com**.

> *Your HA Information Is Confidential*
>
> The HA is strictly confidential. Your health-related information is not shared with FCPS, in compliance with state and federal privacy laws.

Please note that the wellness credit and plan design are subject to change in future years. **Please refer to http://www.ih-aetna.com for additional information.**

> ***It is important to make sure that A/IH has your current phone number so they can reach you. To update your phone number, call Customer Service at 1-888-236-6249. Changes to your mailing address must be filed with FCPS, who will transmit your new address to A/IH.***

Maternity Incentive

The Plan covers a free, confidential maternity management program called the Maternity Management Program. The Program is designed to provide expectant mothers with special attention for a healthy pregnancy. Any pregnant member who is covered by the Aetna/Innovation Health medical plan is eligible to enroll in the Program. Please call **1-800-CRADLE-1** (**1-800-272-3531**) to enroll.

In addition, eligible members who enroll in the Program (by completing a Pregnancy Risk Survey) and who also complete a Post-Partum Survey may be eligible for a Health Incentive Credit (HIC) of up to $150. The HIC will be applied to unmet future deductible and/or coinsurance amounts for you or covered members of your family. The total HIC of $150 is available to those completing both components of the Program as described below.

- **Part 1:** Earn $75 after completion of the Pregnancy Risk Survey (PRS) before reaching your 16th week of pregnancy. The PRS responses help to determine the program materials and services that are right for you. If you have health issues or risks factors that need special attention, Program nurses, in conjunction with your private physician, can provide you a personal case manager to find ways to lower your risks. Once you have completed the PRS, you will be enrolled in the Program. To take the PRS and enroll in the Program, call **1-800-CRADLE-1** (**1-800-272-3531**).
- **Part 2:** Earn $75 after completion of the Post-Partum Survey (PPS). The PPS is done via phone* by a nurse who will call you starting approximately four weeks after the birth of your child. If you are unable to be reached initially, the nurse will make multiple attempts to reach you, up to 4 times. If you miss the call, the nurse will leave a voicemail with call-back instructions. Members have up until 8 weeks post-partum to complete the PPS and qualify for the $75 HIC.

Please note – both actions must be completed to obtain the full $150 HIC. If you do not complete the PRS, you will not be eligible for the PPS.

Please note that the Health Incentive Credit and plan design are subject to change in future years. **Please refer to http://www.ih-aetna.com for additional information.**

It is important to make sure that A/IH has your current phone number so they can reach you. To update your phone number, call Customer Service at 1-888-236-6249. Changes to your mailing address must be filed with FCPS, who will transmit your new address to A/IH.

Disease Management

Whether you are managing a chronic condition or learning what a new diagnosis means for you, the Aetna Health Connections℠ disease management program can help you:

- Understand your doctor's treatment plan
- Recognize any side effects of your medicine
- Work on your doctor's advice, like lowering your cholesterol
- Reach healthy steps, like getting active or making good food choices

You can choose online coaching programs, if that's most convenient for you. Or you can work one-on-one with a registered nurse as your health coach. Stay in contact with the nurse by phone or email – whatever works best for you. Participation in the program is confidential and FCPS does not receive any identifiable health information, in accordance with state and federal privacy laws.

If you'd like to participate, call Aetna Health Connections at **1-866-269-4500**. Aetna/Innovation Health may also reach out to you, based on a physician referral, your medical claims or your annual health assessment. There is no cost to you for participating in the program.

Advanced Illness Resources

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

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient's pain and symptoms.
- Call Member Services at **1-888-236-6246** to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at **www.aetnacompassionatecare.com**.

Aetna Oncology Solutions[SM]

The Aetna Oncology Solutions program helps doctors make treatment decisions based on medical evidence and research, including the choice of cancer drugs.

You do not need to do anything differently to be part of this program. You access cancer care from your selected participating oncologist and he or she will let you know whether additional support is available.

Call Member Services at **1-888-236-6246** to learn more and find out if Aetna Oncology Solutions is available in your location.

Transplant and Special Medical Care

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

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

These services must be preauthorized by Aetna.

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

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

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

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

Keep in Mind

The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does ***not*** cover treatment considered **experimental or investigational** (as determined by Aetna).

Travel and lodging expenses must be approved in advance by Aetna. The Plan does ***not*** cover expenses that are not approved.

Your ID Card

You will receive an ID card when you enroll in the Plan. You are encouraged to carry your ID card with you at all times. Present the card to medical providers before receiving services. If your card is lost or stolen, please notify Aetna immediately.

Be sure to keep your ID card handy and show it whenever you receive care. If you lose your card, call Member Services or log on to your secure member website at **www.aetna.com** to request a replacement or print a temporary card.

Coordination With Other Plans

Effect of Another Plan on This Plan's Benefits

If you have coverage under other group plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may reduce the benefits you receive from this Plan. The adjustment is known as coordination of benefits (COB).

Benefits available through other group plans are coordinated with this Plan. "Other group plans" include any other plan of dental or medical coverage provided by any group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured.

- In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.
- Other plans are defined as any other plan of health expense coverage under:
  - Group insurance.
  - Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.

To find out if benefits under this Plan will be reduced, Aetna must first use the rules listed below, in the order shown, to determine which plan is primary (pays its benefits first). The first rule that applies in the chart below will determine which plan pays first:

If . . .	**Then . . .**
1. One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
2. One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
3. You are eligible for Medicare and actively working	These Medicare Secondary Payer rules apply: • The plan that covers you as an active employee pays first. • The plan that covers you as a dependent of a working spouse determines its benefits and pays next. • Medicare pays third.
4. A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. *Example: A child's mother's birthday is on May 1. The child's father's birthday is on July 4. Since the mother's birthday is earlier in the year, the mother's plan pays first.* If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.

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

If you or your dependents are covered under another group or individual plan, it is your responsibility to make sure that itemized bills are submitted to both carriers. Aetna and your other carrier will determine payment.

How This Plan Coordinates Benefits for Active Employees and Retirees Not Covered by Medicare

On occasion, members may subscribe to more than one group or individual health care plan. Aetna will coordinate benefit payments with your other group or individual health care plans so that you will receive up to, but not more than, what this Plan would pay in the absence of the other coverage. This is commonly referred to as Maintenance of Benefits.

Here's how Maintenance of Benefits works:

- Aetna calculates the amount this Plan would pay if it were the only coverage in place, *then subtracts*
- Benefits paid by the other plan(s).

This ensures that, in total, you receive the benefits available under this Plan.

An example of how this Plan coordinates benefits when other coverage is primary is shown below:

	Primary Plan	**Aetna/Innovation Health Plan**
Total bill:	$2,000	$2,000
Allowed amount:	$1,500	$1,500
Amount paid by primary plan (assumes procedure paid at 80%)	$1,200	
Participant liability from primary plan	$300	
Amount this Plan would have paid (assumes deductible has been met and procedure paid at 90%)		$1,350
Less amount paid by primary plan		($1,200)
Participant responsibility after both plans pay		**$150**

The Aetna/Innovation Health Plan will pay $150, leaving a total participant balance of $150. Please note that your actual claim payment may vary from this example and is dependent on a number of factors, including deductibles, payment of benefits by the primary plan, allowed amounts and participating provider status.

Claims and Appeals

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

Types of Claims

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

Urgent care claim: A claim for medical care or treatment where delay could seriously jeopardize your life or health or your ability to regain maximum function, or subject you to severe pain that cannot be adequately managed without the requested care or treatment.

Pre-service claim: A claim for a benefit that requires Aetna's approval of the benefit in advance of obtaining medical care (precertification).

Concurrent care claim extension: A request to extend a course of treatment that was previously approved.

Concurrent care claim reduction or termination: A decision to reduce or terminate a course of treatment that was previously approved.

Post-service claim: A claim for a benefit that is not a pre-service claim and did not require benefit approval in advance of obtaining care.

Keeping Records of Expenses

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

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

Filing Claims

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

File your claims promptly – ***the filing deadline is one year after the date you incur a covered expense***.

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

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

Physical Exams

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

Time Frames for Claim Processing

Aetna will make a decision on your claim.

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

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

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

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

Extensions of Time Frames

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

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

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

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

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

Notice of Claim Denial

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

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

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

- The individual is not eligible to participate in the Plan; or
- Aetna determines that a benefit or service is not covered by the Plan because:
  – It is not included in the list of covered benefits;
  – It is specifically excluded;
  – It is not medically **necessary**; or
  – A Plan limit or maximum has been reached.

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

- The reason or reasons that your claim was denied.
- A reference to the specific plan provisions on which the denial was based.
  – If an internal rule, guideline, protocol or other similar criterion was relied upon to determine a claim, you'll either receive:
    - A copy of the actual rule, guideline, protocol or other criterion; or
    - A statement that the rule, guideline, protocol or other criterion was used and that you can request a copy free of charge.

- If the denial is based on a Plan provision such as medical necessity, experimental treatment, or a similar exclusion or limit, you'll either receive:
  - An explanation of the scientific or clinical judgment for the determination; or
  - A statement that you can receive the explanation free of charge upon request.
- A description of any additional material or information needed to perfect the claim and the reason why the material or information is necessary.
- An explanation of the Plan's claim review and appeal procedures, applicable time limits and a statement of your rights to bring a civil action after completing all required levels of appeal.
- An explanation of the expedited claim review process for an urgent care claim. In the case of an urgent care claim, the Plan may notify you by phone or fax, then follow up with a written or electronic notice within three days after the notification.

Appealing a Medical Claim Decision

Three Steps in the Appeal Process

The Plan provides for two levels of appeal to Aetna, plus an option to seek external review:

- You must request your first appeal (level one) within 180 calendar days after you receive the notice of a claim denial.
- If you are dissatisfied with the outcome of your level one appeal to Aetna, you may ask for a second review (a level two appeal). You must request a level two appeal no later than 60 days after you receive the level one notice of denial.
- After you have exhausted the level one and level two appeal process, you may file a voluntary appeal for external review if your claim meets certain requirements. You must submit a request for external review within 123 calendar days of the date you receive a final denial notice.

How to Appeal a Claim Denial

Your level one and level two appeals may be submitted in writing or by making a phone call to Member Services. Your appeal should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of the adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

Send your appeal to Member Services at the address shown on your ID card, or call Member Services at the toll-free telephone number shown on your ID card.

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

Type of Claim	Level One Appeal	Level Two Appeal
Urgent care claim	36 hours	36 hours
Pre-service claim	15 calendar days	15 calendar days
Concurrent care claim extension	Treated like an urgent care claim or a pre-service claim, depending on the circumstances	Treated like an urgent care claim or a pre-service claim, depending on the circumstances
Post-service claim	30 calendar days	30 calendar days

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

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

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

Exhaustion of Internal Appeals Process

Generally, you must complete all the Plan's appeal levels before asking for an external review or bringing an action in litigation. However, if Aetna (or the Plan or its designee) does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements. This is known as deemed exhaustion. When this occurs, you may proceed with external review.

Exception

There is an exception to the deemed exhaustion rule. You cannot submit your claim or internal appeal directly to external review if the rule violation was:

Minor and not likely to influence a decision or harm you; and

For a good cause or was beyond Aetna's or the Plan's (or its designee's) control; and

Part of an ongoing good faith exchange between you and Aetna or the Plan; and

Not part of a pattern or practice of violations by Aetna or the Plan.

If the claims procedures have not been strictly adhered to, you have the right to request a written explanation of the violation from Aetna or the Plan. Within 10 days after receiving your request, Aetna or the Plan will give you an explanation of the basis, if any, for asserting that the violation should not cause the internal claim and appeal process to be deemed exhausted. If an external reviewer or court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit your claim and pursue the internal appeal of the claim.

External Review

You may file a voluntary appeal for external review of any final appeal determination that qualifies. An external review is a review of an adverse benefit determination by an external review organization (ERO).

If you file for a voluntary external review, any applicable statute of limitations will be tolled (suspended) while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

> *Keep in Mind*
>
> You do not have to file for voluntary review. After you exhaust the Plan's two standard levels of appeal, you may pursue external review. Your decision to decline the voluntary review process is not considered a failure to exhaust your administrative remedies.

Claims That Qualify for External Review

You may request an external review of a rescission (coverage that was cancelled or discontinued retroactively) or a claim denial based on medical judgment if:

- You have exhausted the Plan's appeal process; or
- Aetna (or the Plan or its designee) has not strictly followed all claim determination and appeal requirements under federal law (except for minor violations).

A denial based upon your eligibility does not qualify for external review.

You must complete all of the levels of standard appeal before you can request an external review, except in a case of deemed exhaustion (see Exhaustion of the Internal Appeals Process for an explanation of deemed exhaustion). Your authorized representative may act on your behalf in filing and pursuing this voluntary appeal, subject to any Plan verification procedures.

Deadline for Requesting an External Review

You must submit a request for external review in writing, using the Request for External Review form. You can ask Member Services at **1-888-236-6249** for a copy of the form. Submit the request within 123 calendar days of the date you receive a final denial notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

Any request for external review must be made in writing, except in the case of an urgent care medical claim, which can also be made orally.

Preliminary Review

Aetna will do a preliminary review of your request for an external review within five days of receiving the request. The preliminary review determines whether:

- You were covered under the Plan at the time the service was requested or provided;
- The adverse determination does not relate to eligibility;
- You have exhausted the internal appeals process (unless deemed exhaustion applies); and
- You have provided all paperwork necessary to complete the external review.

Aetna must notify you in writing of the results of the preliminary review within one business day after completing the review.

- If your request is complete but not eligible for external review, Aetna's notice will include the reasons why it is not eligible and provide contact information for the Employee Benefits Security Administration (toll-free number **1-866-444-3272**).
- If the request is not complete, Aetna's notice will describe the information or materials needed to make the request complete. Aetna must allow you to perfect the request for external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to ERO

If your request for external review is approved, Aetna will assign an accredited ERO to conduct the review. The ERO will notify you in writing that your request is eligible and accepted for review and give you an opportunity to submit additional information that the ERO must consider when conducting the review.

A neutral, independent clinical reviewer, with appropriate expertise in the area in question, will review your material. The decision of the external reviewer is binding unless otherwise allowed by law.

The ERO will review all of the information and documents received within required time frames. In reaching a decision, the assigned ERO will not be bound by any decisions or conclusions reached during the Plan's claims and appeals process. The ERO will consider the following in reaching a decision, as appropriate:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the final decision within 45 days after receiving the request for external review. The ERO must deliver the final decision to you, Aetna and the Plan.

Expedited External Review

The Plan must allow you to request an expedited external review at the time:

- You receive an adverse benefit determination, if:
  - That determination involves a medical condition for which the timeframe for completing an expedited internal appeal (the standard level one and level two appeal process) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; and
  - You have filed a request for an expedited internal appeal; or
- You exhaust the internal appeal process (level one and level two), if:
  - You have a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
  - It concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

As soon as Aetna receives your request for an expedited external review, Aetna will determine whether the request meets the reviewability requirements for standard external review and immediately notify you of its determination.

If your request for an expedited external review is approved, Aetna will assign an ERO. The ERO will make a decision as quickly as your medical condition or circumstances require, and within 72 hours after the ERO receives your request for the expedited review. If the ERO gives you its decision orally, the ERO must follow up with written confirmation to you, Aetna and the Plan within 48 hours of making the decision.

Claim Fiduciary

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

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

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

Aetna is the Claim Fiduciary for the Plan and has discretionary authority to review all denied claims for benefits under the Plan.

Complaints

The Plan has procedures for you to follow if you want to make a complaint about an operational service or a network provider issue. You must write to Member Services within 30 days of the incident. Include a detailed description of the matter and include copies of any records or documents that you think are relevant. Aetna will review the information and give you a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed, but cannot be obtained within this time frame. The notice of the decision will tell you what you need to do to seek an additional review.

Recovery of Overpayment

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

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

Glossary

The Glossary defines the words and phrases in **bold type** that appear throughout the text of this book.

Ambulance
A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Behavioral Health Provider
A licensed organization or professional providing diagnostic, therapeutic or psychological services for the treatment of mental health and substance abuse. Behavioral health providers include hospitals, treatment facilities, psychiatric physicians, psychologists and social workers.

Brand-Name Drug
A **prescription drug** that is protected by trademark registration.

Coinsurance
The sharing of covered expenses by the Plan and the covered person. The percentage of covered expenses paid by the Plan is the Plan's coinsurance. The percentage of covered expenses that you pay is your coinsurance. The Summary of Benefits shows you the coinsurance that you pay and what the Plan pays for covered expenses.

Companion
This is a person who needs to be with an **NME patient** to enable him or her:

- To receive services in connection with an NME (National Medical Excellence) procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

Copay/Copayment
This is a fee that you pay at the time you receive a covered service.

Custodial Care
This means services and supplies, including **room and board** and other institutional care, provided to help you in the activities of daily life. You do not have to be disabled. Such services and supplies are custodial care no matter who prescribes, recommends or performs them.

Deductible
This is the amount of covered expenses that a Plan participant must pay each calendar year before the Plan begins paying benefits.

Dentist
This means a legally qualified dentist or a **physician** licensed to do the dental work he or she performs.

Detox/Detoxification
This is care mainly to overcome the aftereffects of a specific episode of drinking or substance abuse.

Directory
This is a listing of in-network providers in the service area covered under the Plan. A current list of in-network providers may be obtained from Member Services and is also available through the online provider directory. You can access the directory at **www.aetna.com** or at **http://www.ih-aetna.com/fcps**.

Durable Medical Equipment
This is equipment – and the accessories needed to operate it – that is:

- Made to withstand prolonged use;
- Made for and used mainly in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to people who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

The Plan does not allow for more than one item of equipment for the same or similar purpose. Durable medical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency Admission
This means a hospital admission when the physician admits you to the **hospital** right after the sudden and, at that time, unexpected onset of a change in your physical or mental condition:

- That requires confinement right away as a full-time inpatient; and
- For which, if immediate inpatient care were not given, could (as determined by Aetna) reasonably be expected to result in:
  - Placing your health in serious jeopardy; or
  - Serious impairment to bodily function; or
  - Serious dysfunction of a body part or organ; or
  - Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Care
This means the treatment given to you in a hospital's emergency room to evaluate and treat medical conditions of recent onset and severity – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

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

Emergency Condition
This means a recent and severe medical condition – including (but not limited to) severe pain – that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that your condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

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

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

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

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

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

Where Can I Find More Information?
Examples of how this evidence is applied to specific treatments and conditions, called Clinical Policy Bulletins, can be found at **www.aetna.com**.

Habilitation Therapy Services
Habilitation therapy services are services that 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).

Home Health Care Agency
This is an agency that:

- Provides mainly skilled nursing and other therapeutic services; and

- Is associated with a professional group (of at least one physician and one **RN)** that makes policy; and
- Has full-time supervision by a physician or an RN; and
- Keeps complete medical records for each patient; and
- Has an administrator; and
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment in your home. It must be:

- Prescribed in writing by the attending physician; and
- An alternative to inpatient hospital or **skilled nursing facility** care.

Hospice Care
This is care provided to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency
This is an agency or organization that:

- Has **hospice care** available 24 hours a day;
- Meets any licensing or certification standards established by the jurisdiction where it is located;
- Provides:
  - Skilled nursing services; and
  - Medical social services; and
  - Psychological and dietary counseling;
- Provides, or arranges for, other services that include:
  - Physician services; and
  - Physical and occupational therapy; and
  - Part-time home health aide services that consist mainly of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management;
- Has at least the following personnel:
  - One physician; and
  - One RN; and
  - One licensed or certified social worker employed by the agency;
- Establishes policies about how hospice care is provided;
- Assesses the patient's medical and social needs;
- Develops a hospice care program to meet those needs;

- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the agency;
- Permits all area medical personnel to utilize its services for their patients;
- Keeps a medical record for each patient;
- Uses volunteers trained in providing services for non-medical needs; and
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **hospice care** that:

- Is established by and reviewed from time to time by your attending physician and appropriate hospice care agency personnel;
- Is designed to provide palliative (pain relief) and supportive care to terminally ill people and supportive care to their families; and
- Includes an assessment of your medical and social needs, and a description of the care to be given to meet those needs.

Hospital
This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons;
- Is supervised by a staff of physicians;
- Provides 24-hour-a-day RN service;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home; and
- Charges for its services.

Infertile or Infertility
Infertility is a condition that is defined by the failure to achieve successful pregnancy:

- After 12 months or more of unprotected heterosexual intercourse (after six months in women over 35 years of age); or
- In those women, without a male partner, who are unable to conceive after at least 12 cycles of donor insemination (six cycles for women over 35 years of age).

You can find more information about infertility services in the Coverage Policy Bulletins (CPBs) available at **www.aetna.com**. If you have questions, call Member Services at **1-888-236-6249**.

Inherited Metabolic Disease
An inherited metabolic disease is caused by a genetic defect that lead to life threatening abnormalities in body chemistry. Examples include, but are not limited to, phenylketonuria, hyperphenylalaninemia, ketoaciduria, histidinemia, homocystinuria, organic acidemias, tyrosinemia and urea cycle disorders.

In-Network Care
This is a health care service or supply furnished by:

- An **in-network provider**; or
- A health care provider who is not an in-network provider when there is an emergency condition and travel to a provider in the network is not possible.

In-Network Provider
This is a health care provider who has contracted to furnish services or supplies for a **negotiated charge**, but only if the provider is included in the directory as a preferred care provider for the service or supply involved.

LPN
This means a licensed practical nurse.

Mental Disorder
This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis. Treatment for mental disorders is usually provided by or under the direction of a behavioral health provider such as a psychiatrist, psychologist or psychiatric social worker. Mental disorders include (but are not limited to):

- Alcohol and substance abuse
- Schizophrenia
- Bipolar disorder
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

NME Patient
This is a person who:

- Needs any of the National Medical Excellence (NME) program procedure and treatment types covered by the Plan; and
- Contacts Aetna and is approved by Aetna as an NME patient; and
- Agrees to have the procedure or treatment performed in a hospital that Aetna determines is the most appropriate facility.

Necessary/Medically Necessary
Health care services and supplies that a **physician**, other health care provider or **dentist**, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an **illness**, **injury** or disease. The service or supply must be:

- Provided in accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician, dentist or other health care provider; and

- Not more costly than an alternative service or sequence of services that would be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical or dental practice" means standards that are:

- Based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community; or
- Otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

Negotiated Charge
This is the maximum fee an in-network provider has agreed to charge for any service or supply for the purpose of benefits under this Plan.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be considered non-occupational regardless of its cause if proof is provided that you:

- Are covered under any type of Workers' Compensation law; and
- Are not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- Result from (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-Urgent Admission
An admission that is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any medical or dental service or supply given to prevent, diagnose or correct a misalignment of:

- The teeth;
- The bite; or
- The jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Care
This is a health care service or supply provided by an **out-of-network provider** if, as determined by Aetna, the provider does not belong to one or more of the provider categories in the **directory**.

Out-of-Network Provider
This is a health care provider who does not belong to Aetna/Innovation Health's network and has not contracted with Aetna/Innovation Health to furnish services or supplies at a negotiated charge**.**

Out-of-Pocket Maximum
The out-of-pocket maximum is the maximum that you must pay out of pocket for covered expenses each calendar year.

Partial Confinement Treatment
A medically supervised day, evening and/or night treatment program for mental health or substance abuse disorders. Care is coordinated by a multidisciplinary treatment team. Services are provided on an outpatient basis for at least four hours per day and are available at least three days per week. The services are of the same intensity and level as inpatient services for the treatment of behavioral health disorders.

Physician
This means a legally qualified physician. The term "doctor" is also used throughout this book and has the same meaning as "physician."

Precertification
This is a review of certain types of care to determine whether the proposed care is covered by the Plan. This review takes place before the care is given.

Prescription
A **prescriber**'s order for a prescription drug. This can include an oral order (such as a phoned-in prescription), written, or an electronic order.

Prescription Drugs
Any of the following:

- A drug, biological or compounded prescription that, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without prescription."
- An injectable contraceptive drug prescribed to be administered by a paid health care professional.
- An injectable drug prescribed to be self-administered or administered by another person except someone who is acting within his or her capacity as a paid health care professional. Covered injectable drugs include insulin.
- Disposable needles and syringes purchased to administer a covered injectable prescription drug.

Psychiatric Hospital
An institution that meets ***all*** of the following criteria:

- Mainly provides a program for the diagnosis, evaluation and treatment of mental disorders or alcohol or substance abuse.
- Is not mainly a school or custodial, recreational or training institution.
- Provides infirmary-level medical services.
- Provides, or arranges with a hospital in the area to provide, any other medical service that may be needed.
- Is supervised full-time by a psychiatric physician who is responsible for patient care.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient. The plan must be supervised by a psychiatric physician.
- Charges for its services.
- Meets licensing standards.

RN
This means a registered nurse.

Recognized Charge
The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider's full charge.

> *Please Note*
> The Plan's recognized charge applies to all covered out-of-network expenses except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is in the network. It also applies when your PCP or other network provider refers you to a provider that is not in the network.
>
> ***Before*** getting care, use the *Member Payment Estimator* and other tools available on your secure member website at **www.aetna.com**. These tools can help you estimate the cost of a service or supply and decide whether to get care in the network or out-of-network.

For medical, vision and hearing expenses, the **recognized charge** for each service or supply is the lesser of what the provider bills or submits for a service or supply and:

- For professional services and other services or supplies not mentioned below: 125% of the Medicare allowable rate.
- For services of hospitals and other facilities: 125% of the Medicare allowable rate.

The recognized charge is determined based on the geographic area where you receive the service or supply.

If there is an agreement with a provider (directly, or indirectly through a third party) which sets the rate that will be paid for a service or supply, then the recognized charge is the rate established in such agreement.

The recognized charge may also be reduced by applying Aetna's reimbursement policies. Reimbursement policies address the appropriate billing of services taking into account factors such as:

- The duration and complexity of a service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required;
- Whether an assistant surgeon is involved and **necessary** for the service;
- Whether follow-up care is included;
- Whether there are any other factors that modify or make the service unique;
- The provider's educational level, licensure or length of training; and
- Whether any services are part of or incidental to the primary service provided if the charge includes more than one claim line.

Aetna's reimbursement policies are based on:

- 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; and
- The views of physicians and dentists practicing in the relevant clinical areas.

Aetna uses a commercial software package to administer some of these policies.

As used above, "geographic area" and "Medicare allowable rates" are defined as follows:

- Geographic area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If Aetna determines that more data is needed for a particular service or supply, Aetna may base rates on a wider geographic area, such as an entire state.
- Medicare allowable rates: Except as described below, these are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, Aetna will determine a rate as follows:
  - Use the same method that CMS uses to set Medicare rates.
  - Look at what other providers charge.
  - Look at how much work it takes to perform a service.
  - Look at other things, as needed, to decide what rare is reasonable for a particular service or supply.

Important Note

Aetna periodically updates its systems with changes made to the Medicare Allowable Rates. *What this means to you* is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Room and Board Charges

Charges made by an institution for room and board and other **necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

Semi-Private Room Rate

This is the **room and board charge** that an institution applies to the most beds in its semi-private rooms with two or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility

This is an institution that:

- Is licensed or approved under state or local law;
- Qualifies as a skilled nursing facility under Medicare, or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities.
- Is primarily engaged in providing skilled nursing care and related services for residents who need:
  - Medical or nursing care; or
  - Rehabilitation services because of injury, illness or disability;
- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - Professional nursing care by an RN, or by an LPN directed by a full-time RN; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time RN;
- Is supervised full-time by a physician or RN;
- Keeps a complete medical record for each patient;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for people who are mentally retarded, or for custodial or educational care;
- Is not mainly a place for the care and treatment of alcoholism, substance abuse or mental disorders, and
- Charges for its services.

A skilled nursing facility may be a rehabilitation hospital, or a portion of a hospital designated for skilled or rehabilitation services.

Specialist
A specialist is a physician who practices in any generally accepted medical or surgical sub-specialty, and provides care that is not considered routine medical care.

Substance Abuse
This is a physical and/or psychological dependency on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include:

- Conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment.
- An addiction to nicotine products, food or caffeine intoxication.

Surgery Center
This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians, at least one of whom is on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery that requires general or spinal anesthesia is performed, and during the recovery period.
- Extends surgical staff privileges to physicians who practice surgery in an area hospital and to dentists who perform oral surgery.
- Has at least two operating rooms and one recovery room.
- Provides or arranges with a medical facility in the area for diagnostic X-ray and laboratory services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an RN.
- Is equipped and has staff trained to handle medical emergencies.
- Must have a physician trained in CPR, a defibrillator, a tracheotomy set and a blood volume expander.
- Has a written agreement with an area hospital for the immediate emergency transfer of patients. Written procedures for such a transfer must be displayed, and the staff must be aware of them.
- Provides an ongoing quality assurance program that includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record for each patient.

Terminally Ill
This is a medical prognosis of 12 months or fewer to live.

Treatment Facility (for substance abuse)
This is an institution that:

- Mainly provides a program for diagnosis, evaluation and **effective treatment of alcohol or substance abuse**.
- Charges for its services.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a physician.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed for its effective treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical services that may be required.
  - Supervision by a staff of physicians.
  - Skilled nursing care by licensed nurses who are directed by a full-time RN.

Treatment Facility (for mental disorders)
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time RN.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Charges for its services.
- Meets licensing standards.

Urgent Admission
An urgent admission is one in which the physician admits you to the hospital because of:

- The onset of, or change in, a disease; or
- The diagnosis of a disease; or
- An injury caused by an accident;

that, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for confinement becomes apparent.

Urgent Care Provider
This is a freestanding medical facility that:

- Provides unscheduled medical services to treat an urgent condition if your physician is not reasonably available;
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours;
- Charges for services;
- Is licensed and certified as required by state or federal law or regulation;
- Keeps a medical record for each patient;
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or run the facility;
- Is run by a staff of physicians, with one physician on call at all times; and
- Has a full-time administrator who is a physician.

An urgent care provider may also be a physician's office if it has contracted with Aetna to provide urgent care and is, with Aetna's consent, included in its provider directory as an in-network urgent care provider.

A hospital emergency room or outpatient department is not considered to be an urgent care provider.

Urgent Condition
This is a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious health problems;
- Includes a condition that could cause you severe pain that cannot be managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that can't be postponed until your physician becomes reasonably available.

Walk-In Clinic
A free-standing health care facility that:

- Treats unscheduled and/or non-emergency illnesses and injuries; and
- Administers certain immunizations.

A walk-in clinic must:

- Provide unscheduled and/or non-emergency medical services;
- Make charges for the services provided;
- Be licensed and certified as required by any state or federal law or regulation;
- Be staffed by independent practitioners, such as Nurse Practitioners, licensed in the state where the clinic is located;
- Keep a medical record on each patient;
- Provide an ongoing quality assurance program;
- Have at least one physician on call at all times;
- Have a physician who sets protocol for clinical policies, guidelines and decisions; and
- Not be the emergency room or outpatient department of a hospital.