Benefits Handbook Date January 1, 2023

Aetna Medical Plan Options

Marsh McLennan

Aetna Medical Plan Options

In this document references to Marsh & McLennan Companies mean Marsh McLennan and references to Marsh & McLennan Agency LLC mean Marsh McLennan Agency. Selecting a medical plan option for 2023 involves three key choices for eligible individuals.

SPD and Plan Document

This section provides a summary of the Medical Plan (the "Plan") options available through Aetna as of January 1, 2023.

- Select one of three medical plan design options. A range of coverage levels and costs is offered.
- Select coverage for:
  - yourself only — Employee
  - yourself and your spouse or domestic partner — Employee + Spouse
  - yourself and your child or children — Employee + Child(ren)
  - yourself, your spouse or domestic partner, and children — Family
- Select your medical plan THIRD PARTY ADMINISTRATOR (or carrier with respect to the insured programs):
  - All eligible individuals resident in any state except Hawaii may choose from among:
    - Aetna
    - Anthem BlueCross BlueShield (Anthem BCBS)
    - Surest

    Note: This section of the Benefits Handbook provides information about the Aetna administered medical plan options only.

    Information about the Anthem BlueCross BlueShield and Surest administered medical plan options is covered in a separate section of the Benefits Handbook.
  - Eligible individuals resident in CA, CO, GA, MD, VA, OR, WA, and Washington DC have an additional choice to consider:
    - Kaiser Permanente (Kaiser)

    Information about the Kaiser administered medical plan options is covered in a separate section of the Benefits Handbook.
  - Eligible individuals who are resident in Hawaii, may only choose between:
    - HMSA's Health Plan Hawaii Plus (HMO)
    - HMSA's Preferred Provider Plan (PPP)

    Information about the Hawaii medical plan options is covered in a separate section of the Benefits Handbook.

All medical plan options described in this section of the Benefits Handbook offer:

- comprehensive health services
- the freedom to select between a health care provider that participates in your chosen medical plan THIRD PARTY ADMINISTRATOR'S network, generally at a lower cost to you, or a provider that does not participate in your chosen medical plan third party administrator's network, generally at a higher cost to you.

Note: Be sure to read about Health Care Flexible Spending Accounts (HCFSAs), Health Savings Accounts (HSAs) and Limited Purpose Health Care Flexible Spending Accounts (LPHCFSAs). Understanding these tax-advantaged arrangements may be important to your selection of a medical plan.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this medical plan. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

Contents

The Medical Plan Options at a Glance

The chart below outlines some important Plan features and coverage information that distinguish the two available Aetna medical plan options. The plan features described below (deductibles, COINSURANCE, etc.) are the same under the Broad Network and the Narrow Network. Additional information is provided throughout this section of the Benefits Handbook including the "Detailed List of Covered Services" on page 49.

Plan feature	$1,500 Deductible Plan[1]	$3,000 Deductible Plan[1]
Annual Deductible	***In-network:*** Employee: $1,500 Family[2]: $3,000[4] ***Out-of-network:*** Employee: $3,000 Family[2]: $6,000[4]	***In-network:*** Employee: $3,000 Family[2]: $6,000[3] ***Out-of-network:*** Employee: $6,000 Family[2]: $12,000[3]
Out-of-Pocket Maximum (including DEDUCTIBLE)	***In-network:*** Employee: $3,000 Family[2]: $6,000[4] ***Out-of-network:*** Employee: $6,000 Family[2]: $12,000[4]	***In-network:*** Employee: $5,500 Family[2]: $11,000[3] ***Out-of-network:*** Employee: $11,000 Family[2]: $22,000[3]
Plan Coinsurance	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible (Out-of-network benefits are based on reasonable and customary charges)	**In-network:** 70% coinsurance after deductible **Out-of-network:** 50% coinsurance after deductible (Out-of-network benefits are based on reasonable and customary charges)
Physician office visits		
Preventive Visit	**In-network:** Covered at 100% **Out-of-network**: 60% coinsurance after deductible	**In-network**: Covered at 100% **Out-of-network:** 50% coinsurance after deductible
Primary Care Physician (PCP)/Specialist Visit	**In-network:** 80% coinsurance after deductible **Out-of-network:** 60% coinsurance of R&C after deductible	**In-network:** 70% coinsurance after deductible **Out-of-network:** 50% coinsurance of R&C after deductible
Specialist Visit	**In-network:** 80% coinsurance after deductible **Out-of-network:** 60% coinsurance of R&C after deductible	**In-network:** 70% coinsurance after deductible **Out-of-network:** 50% coinsurance of R&C after deductible

Plan feature	$1,500 Deductible Plan[1]	$3,000 Deductible Plan[1]
Hospital Facility		
Inpatient	**In-network:** 80% coinsurance after deductible **Out-of-network:** 60% coinsurance after deductible	**In-network:** 70% coinsurance after deductible **Out-of-network:** 50% coinsurance after deductible
Outpatient	**In-network:** 80% coinsurance after deductible **Out-of-network:** 60% coinsurance after deductible	**In-network:** 70% coinsurance after deductible **Out-of-network:** 50% coinsurance after deductible
Emergency Room (waived if admitted)	**In and Out-of-network:** 80% coinsurance after deductible	**In and Out-of-network:** 70% coinsurance after deductible
Prescription drugs	There is a CVS Caremark® Retail Pharmacy Network for 30-day supply (acute) and CVS Caremark® Retail and CVS Caremark® Mail Order for 90-day supply (maintenance) PRESCRIPTION DRUGS.	
Retail Prescriptions (30-day supply)		
▪ Generic	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
CVS Caremark® Retail and CVS Caremark® Maintenance Choice Program Mail-order Prescriptions[5] (90-day supply)		
▪ Generic	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
Prescription Drug Programs	There are prescription drug programs available as part of the medical plan options. For information on Rx Savings Solutions, Transform Diabetes® Care, WW Digital Program and Hello Heart, refer to “Prescription Drug Programs” on page 41.	

Plan feature	$1,500 Deductible Plan[1]	$3,000 Deductible Plan[1]
Contact Information for Third Party Administrator options:	Contact for Medical Service: Aetna (Claims Administrator) P.O. Box 981106 El Paso, TX 79998-1106 Aetna Customer Service: +1 866 210 7858 Website: www.aetna.com Contact for Prescription Service: CVS Caremark® (Prescription Drug Benefits Manager) Phone: +1 844 449 0362 Website (for members): www.caremark.com CVS Caremark® Group #: 21CW Marsh McLennan does not administer claims under this plan. For medical claims, the Claims Administrators' decisions are final and binding. For prescription drug claims, the Prescription Drug Benefits Manager's decisions are final and binding.	

1 These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

2 "Family" applies to all coverage levels except Employee-Only.

3 Not "True" Family: For the $3,000 Deductible Plan, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

4 "True" Family: The $1,500 Deductible Plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

5 In addition to mail order, you will be able to fill a 90-day supply of your maintenance medications at a CVS Caremark® retail pharmacy, at the same cost as you would through the mail order program. For all maintenance medications, after the first three fills, you must fill a 90-day supply either at a CVS Caremark® retail pharmacy or through the CVS Caremark® Maintenance Choice Mail Order program otherwise, the maintenance medication will not be covered, you will pay 100% of the full cost for all subsequent fills, and the cost does not accumulate towards the deductible and out-of-pocket maximum.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Retiree Eligibility

Certain retirees and their eligible family members that are not yet deemed to be eligible for Medicare may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage, see the *Participating in Pre-65 Retiree Medical Coverage* section.

Enrollment

To participate in this Plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment (generally in November with respect to coverage for the following calendar year)
- within 60 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this Plan.

Enrollment procedures for you and your eligible family members are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your eligible family members.

The cost of your coverage depends on the plan option and level of coverage you choose. The cost may change each year.

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh McLennan Employees (other than Marsh & McLennan Agency LLC – Northeast (MMA-Northeast) or Security Insurance Services of Marsh & McLennan Agency LLC) is shown below.

	$1,500 Deductible Plan		**$3,000 Deductible Plan**	
Coverage Level	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Broad Network				
Employee Only	$82.46	$38.06	$31.46	$14.52
Employee + Spouse/Domestic Partner	$218.17	$100.69	$104.40	$48.18
Employee + Child(ren)	$164.89	$76.10	$70.85	$32.70
Employee + Family	$308.87	$142.55	$143.37	$66.17
Narrow Network				
Employee Only	$65.96	$30.44	$25.17	$11.62
Employee + Spouse/Domestic Partner	$174.54	$80.56	$83.53	$38.55
Employee + Child(ren)	$131.91	$60.88	$56.68	$26.16
Employee + Family	$247.09	$114.04	$114.69	$52.93

Medical rates are not available for employees of MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency LLC. For contribution rates, contact HR Services at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

The table below shows the imputed income amounts for all eligible Marsh McLennan Employees (including MMA-Northeast and Security Insurance Services of Marsh & McLennan Agency LLC):

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

Imputed Income Rates

Imputed Income for Domestic Partner Coverage				
	$1,500 Deductible Plan		$3,000 Deductible Plan	
Coverage Level	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*
Broad Network				
Employee + Domestic Partner (non-qualified)				
	$466.22	$215.18	$423.62	$195.52
Employee + Child(ren) (non-qualified)				
	$333.01	$153.70	$302.58	$139.65
Employee + Domestic Partner (non-qualified) & Child(ren)				
	$499.53	$230.55	$453.89	$209.49
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) (non-qualified)				
	$832.54	$384.25	$756.47	$349.14
Narrow Network				
Employee + Domestic Partner (non-qualified)				
	$447.56	$206.57	$406.68	$187.70
Employee + Child(ren) (non-qualified)				
	$319.69	$147.55	$290.48	$134.07
Employee + Domestic Partner (non-qualified) & Child(ren)				
	$479.53	$221.32	$435.73	$201.10
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) (non-qualified)				
	$799.22	$368.87	$726.21	$335.17

ID Cards

If you are enrolled in employee only coverage you will automatically be sent one ID card for your medical coverage. You will be sent one additional ID card if you enroll one or more family members in the Plan. Each ID card will list the employee's name and the names of up to five covered family members. You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

There is a separate ID card for prescription drug coverage. For information on prescription drug ID cards, refer to "Prescription Drugs" on page 35.

How the Medical Plan Options Work

All of the medical plan options help you and your family to pay for medical care. As a participant, you may choose, each time you need medical treatment, to use:

- Any physician, hospital or lab, or
- A provider who participates in either the Aetna Choice POSII network (Broad network) or the Aetna Premier Care Network (APCN) (Narrow network) and has agreed to charge reduced fees to the Plan members. Using the network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers.

If you use an in-network provider, you do not need to submit a claim form. In-network providers bill the Claims Administrator directly.

Under the $1,500 Deductible Plan

- Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

Under the $3,000 Deductible Plan

- Generally, the Plan's reimbursement is 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

See the "Detailed List of Covered Services" on page 49 for more detailed information.

Certain expenses are not covered or reimbursed by the Plan, such as any deductible you are required to meet and your share of the amounts above the reasonable and customary charge.

Some services have specific limits or restrictions; see individual service for more information.

Refer to the "What's Not Covered" on page 59 to find out about the services that are not covered under the Plan.

Benefits are only paid for medically necessary charges or for specified wellness care expenses.

Preauthorization may be required in order to receive coverage for certain services. It is the Plan participant's responsibility (not the provider or facility) to obtain preauthorization for out-of-network services. For more information on the preauthorization process and applicable services, refer to the description under "Utilization Review" on page 15.

Member Advocacy

You and your enrolled family members can access support from a personal health representative at no additional cost to you through Aetna One® Advocate. A personal health representative can help you find care and support when you're managing a medical condition or following a major health event.

Aetna One Advocate's designated team will help:

- Put together a personal care plan, schedule appointments with doctors, help set goals for you, work to help resolve claim inquiries or billing issues, find programs to manage a particular medical condition and connect with resources in your community.
- The same assigned representative will remain with you until your issue is resolved and along the way, check in on you when it's convenient.

You can contact the Aetna One Advocate team at + 1 866 210 7858. The Aetna One Advocate team is available:

- Monday through Friday, 8:00 am to 8:00 pm, in your time zone
- Saturday, from 8:00 am to 4:30 pm, in your time zone
- 24/7 for nurse support

Health Savings Account and Flexible Spending Accounts

If you elect the $1,500 Deductible Plan or the $3,000 Deductible Plan, you can elect to participate instead in a Health Savings Account (HSA) and, if you choose, a Limited Purpose Health Care Flexible Spending Account (LPHCFSA).

For details about the FSA, HSA, or the LPHCFSA, see the *Health Care Flexible Spending Account*, *Health Savings Account*, or *Limited Purpose Health Care Flexible Spending Account* sections.

Deductibles

The deductible is the amount that must be paid before the Plan will reimburse any benefits.

The deductibles vary under each of the medical plan options available to you (as shown in the table below.

Plan feature	$1,500 Deductible Plan[1]	$3,000 Deductible Plan[1]
Deductible	***In-network:***	***In-network:***
	Employee: $1,500	Employee: $3,000
	Family[2]: $3,000[4]	Family[2]: $6,000[3]
	Out-of-network:	***Out-of-network:***
	Employee: $3,000	Employee: $6,000
	Family[2]: $6,000[4]	Family[2]: $12,000[3]

[1] These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

[2] "Family" applies to all coverage levels except Employee-Only.

[3] Not "True" Family: For the $3,000 Deductible plan, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

[4] "True" Family: The $1,500 Deductible Plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

Do in-network medical claims apply toward the out-of-network deductible?

Yes. In-network claims apply toward the out-of-network deductible. Also, out-of-network claims apply toward the out-of-network deductible.

Do out-of-network medical claims apply toward the in-network deductible?

Yes. Out-of-network claims apply toward the in-network deductible. Also, in-network claims apply toward the in-network deductible.

How do deductibles work?

Under the $1,500 Deductible Plan

If the "employee" coverage level is elected, the Plan will begin reimbursing benefits for the one covered individual once he or she has met the individual deductible. For any other coverage level (employee + spouse, employee + child(ren) or family, the Plan will begin reimbursing benefits for a covered family member (including a newborn) once the family deductible is met. In meeting your family deductible, each covered family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family deductible. Once this family deductible is met, the Plan will pay benefits for all covered family members.

Under the $3,000 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member once he or she has met the individual deductible (even if the entire family deductible has not been met).

(Note that newborns have their own separate deductible.) The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. Newborn expenses, including nursery charges in the hospital, will apply to newborn's individual deductible.

Do I have to meet a new deductible every year?

You and your family members will have to meet a new deductible each year.

What expenses apply toward the deductible?

Most of your medical expenses apply toward the deductible.

Under the $1,500 Deductible Plan and the $3,000 Deductible Plan, prescription drug expenses (other than preventive drug expenses) apply toward the deductible.

Refer to "Do preventive drug expenses apply toward the deductible?" on page 10 for further details.

Your payments for the following don't apply toward the Plan deductible:

- Amounts in excess of a reasonable and customary charge
- Preauthorization penalties
- Services not covered by the Plan

Under the $1,500 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Under the $3,000 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Do preventive drug expenses apply toward the deductible?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $1,500 Deductible Plan and $3,000 Deductible Plan are covered with no cost sharing (i.e. deductible, coinsurance, copay). Certain examples include: aspirin products, fluoride products, folic acid products, immunizations, contraceptive methods, smoking cessation products, bowel preps, primary prevention of breast cancer and statins. The list of preventive medications covered with no cost sharing, called the CVS Caremark ACA Drug List, is subject to periodic review and may change.

If you enrolled in the $1,500 Deductible Plan or the $3,000 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs. This list of preventive medications, the CVS Caremark Preventive Drug List, is covered at the standard coinsurance and the list of medications is subject to periodic review and change.

Call CVS Caremark® at +1 844 449 0362 for more information about preventive drugs. You can access the preventive drug listing at www.caremark.com. To obtain information on the cost of preventive drugs, log on to the Drug Cost Tool at www.caremark.com. Follow the provided steps to access the Drug Cost Tool.

- Go to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Check Drug Cost & Coverage.
- Enter drug name & dose and choose a pharmacy.

Out-of-Pocket Maximums

The maximum amount you have to pay toward the cost of the medical care you receive in the course of one year (excluding your per paycheck contributions to participate in the Plan). The out-of-pocket maximums vary under each of the medical plan options as follows:

Plan feature	$1,500 Deductible Plan[1]	$3,000 Deductible Plan[1]
Out-of-pocket maximum (including DEDUCTIBLE)	***In-network:*** Employee: $3,000 Family[2]: $6,000[4] ***Out-of-network:*** Employee: $6,000 Family[2]: $12,000[4]	***In-network:*** Employee: $5,500 Family[2]: $11,000[3] ***Out-of-network:*** Employee: $11,000 Family[2]: $22,000[3]

1 These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

2 "Family" applies to all coverage levels except Employee-Only.

3 Not "True" Family: For the $3,000 Deductible Plans, if more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a covered family member meets his or her individual deductible, benefits begin for that covered family member only, but not for the other covered family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible can only be met by a combination of covered family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a covered family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that covered family member only, but not for the other covered family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum can only be met by a combination of covered family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

4 "True" Family: The $1,500 Deductible Plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one covered family member or a combination of covered family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one covered family member or a combination of covered family members.

Prescription drug expenses apply toward the out-of-pocket maximum.

The out-of-pocket maximum doesn't apply to:

- Amounts exceeding Plan limits
- Amounts in excess of a reasonable and customary charge
- Expenses for non-emergency use of the emergency room
- Expenses incurred for non-urgent use of an urgent care provider
- Preauthorization penalties
- Services not covered by the Plan
- Amounts exceeding the network negotiated price for prescription drugs.

Your deductible applies toward your out-of-pocket maximum.

Do in-network medical claims apply toward the out-of-network out-of-pocket maximum?

Yes. In-network claims apply toward the out-of-network out-of-pocket maximum. Also, out-of-network claims apply toward the out-of-network out-of-pocket maximum.

Do out-of-network medical claims apply toward the in-network out-of-pocket maximum?

Yes. Out-of-network claims apply toward the in-network out-of-pocket maximum. Also, in-network claims apply toward the in-network out-of-pocket maximum.

How does the annual out-of-pocket maximum (limit) work for family members?

Under the $1,500 Deductible Plan

In meeting your family out-of-pocket maximum, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family out-of-pocket maximum.

If you cover eligible family members, you must meet the family out-of-pocket maximum. Once this out-of-pocket maximum has been met, the Plan will pay benefits for all family members at 100% for in-network providers and 100% of reasonable and customary charges for out-of-network providers.

Under the $3,000 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Networks

Aetna Choice POSII Broad network is available nationally. Aetna Premier Care Network (APCN) Narrow network is available in select geographies.

Is there a network of doctors and hospitals that I have to use?

Using the network is not mandatory, but generally, you will receive a higher reimbursement when using the network. If you use an in-network provider, you will be reimbursed 80% (70% under the $3,000 Deductible Plan). If you use an out-of-network provider, you will be reimbursed 60% (50% under the $3,000 Deductible Plan) of reasonable and customary charges for covered expenses after the Plan's deductible has been met.

In the event that you receive care from an out-of-network doctor (such as an anesthesiologist) while being treated at an in-network facility, benefits will be paid at the in-network level.

The network includes general practitioners, as well as specialists and hospitals. These network providers are selected by and contracted with the Claims Administrator.

Where can I get a directory that lists all the doctors and hospitals in the network?

The doctors and hospitals in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers or you may call the Claims Administrator.

Network provider lists can change, so take the time to review the networks to determine which networks your health care providers participate in before choosing a THIRD PARTY ADMINISTRATOR and network.

Important: In-network participating providers can change at any time; therefore, the network information you gather may not be accurate for all or part of the plan year. You will NOT be permitted to change your medical plan election during the plan year, even if any or all of your providers stop participating in any network at any point during the plan year.

Finding your ZIP code in the provider search does not mean that you are eligible for a narrow network; you must confirm you're eligible for a narrow network in the Mercer Marketplace Benefits Enrollment Website. Aetna determines the ZIP codes that are included within their narrow network.

Call Member Services at +1 866 210 7858 or visit aetna.com. On the Aetna website:

- Select **Find a doctor**.
- Under Guests, select **Plan from an employer**.
- Under Continue as a guest, **enter** either ZIP Code, City, County or State. Specify your preferred distance range and select **Search**.
- For the **Narrow Network**: Under Select a Plan, scroll down to **Aetna Premier Care Network** and under 2023 Plan Providers, select **Aetna Premier Care Network (APCN) Choice POS II/ Open Access Managed Choice** and select **Continue**.

- For the **Broad Network**: Under Select a Plan, scroll down to **Aetna Open Access Plans** and check **Aetna Choice POS II (Open Access)** and select **Continue**.
- Enter the provider's name or specialty—or search by category.
- **Note: If you want to enroll in a narrow network, be sure to check that your providers participate in the narrow network. You can do this by following the instructions above. Please note that if you're enrolled in a broad network and want to switch to a narrow network, you should follow the instructions for searching for narrow network participating providers. Important: If you're currently enrolled in a broad network, DO NOT log into your medical plan account to look for narrow network providers. If you do log into your medical plan account, you'll see only providers who participate in the broad network. You should follow the instructions above to check for narrow network providers**.

Is there a network of providers for mental health treatment?

There is a network of mental health providers. Providers in the network are listed in a provider directory. The Claims Administrator provides an online directory available at www.aetna.com. You may also call the Claims Administrator.

Network provider lists can change, so take the time to review the networks to determine which networks your health care providers participate in before choosing a THIRD PARTY ADMINISTRATOR and network.

Important: In-network participating providers can change at any time; therefore, the network information you gather may not be accurate for all or part of the plan year. You will NOT be permitted to change your medical plan election during the plan year, even if any or all of your providers stop participating in any network at any point during the plan year.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan with CVS Caremark®. You may use a pharmacy in the network as well as out-of-network to receive coverage under this Plan.

Note that when you go to a pharmacy that's out-of-network, you need to submit a claim form for reimbursement. Refer to "How do I file a prescription drug claim form?" in the Filing a Claim section for more information.

The Prescription Drug Benefits Manager, with CVS Caremark®, provides an online directory of network pharmacies available at www.caremark.com.

To locate an in-network retail pharmacy:

- Go to www.caremark.com.
- Login or create an account.

- Plan & Benefits.
- Pharmacy Locator.

Or call CVS Caremark® at +1 844 449 0362 for more information.

Utilization Review

Which utilization review services are offered?

The Plan offers preauthorization and case management review.

You may obtain more information about these review services by calling the Claims Administrator.

What is Preauthorization?

Preauthorization is a utilization review service performed by licensed healthcare professionals. The intent is to determine medical necessity and appropriateness of proposed treatment, including level of care, benefit coverage and eligibility.

In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided preauthorization.

What services require preauthorization?

The following types of medical expenses require preauthorization:

- INPATIENT confinements (except HOSPICE)
- Ambulance
  - Precertification required for transportation by fixed-wing aircraft (plane)
- Applied Behavioral Analysis (ABA)
- Autologous chondrocyte implantation
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Coverage at an in-network benefit level for out-of-network provider or facility unless services are emergent.
- Dental implants
- Dialysis visits
  - When a participating provider initiates request, and dialysis is to be performed at a nonparticipating facility call +1 866 752 7021. Or fax applicable request forms to +1 888 267 3277.
- Dorsal column (lumbar) neurostimulators: trial or implantation
- Electric or motorized wheelchairs and scooters

- Endoscopic nasal balloon dilation procedures
- Gender reassignment surgery
- Gene-based, cellular and other innovative therapies (GCIT)
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Infertility services and pre-implantation genetic testing
- Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Osseointegrated implant
- Osteochondral allograft/knee
- Private duty nursing
- Proton beam radiotherapy
- Reconstructive or other procedures that maybe considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomyor excess fat removal
  - Surgery for varicose veins, except stab phlebectomy
- Shoulder Arthroplasty
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery (cervical spine)
  - Cervical laminoplasty – precertification required effective 9/1/2019
  - Cervical, lumbar and thoracic laminectomy and\or laminotomy procedures

  - Laminectomy with rhizotomy
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video electroencephalograph (EEG)
- Whole exome sequencing

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

If you are receiving an infused medication, certain medications may require use of the lowest cost site of care.

Do I need to have my maternity coverage preauthorized?

No. Preauthorization within 48 hours is not required for the initial hospital admission.

You must notify the preauthorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

When do I obtain preauthorization?

You, your family member or health care professional must obtain preauthorization as soon as you know you need a service requiring preauthorization, but not less than 14 days prior to the procedure or treatment.

Note: You are responsible for ensuring your service has been preauthorized.

How do I obtain preauthorization?

Initiate the preauthorization process by calling the Claims Administrator.

What happens if I fail to obtain preauthorization?

If you fail to obtain preauthorization, your out-of-network benefits will be reduced by $400 of covered expenses for inpatient hospital, treatment facility, skilled nursing facility, home health care, private duty nursing and hospice. (Preauthorization penalties do not apply towards your deductible or out-of-pocket maximum.)

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services.

What approvals do I need if I am going into the hospital?

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Case Management Review

When the preauthorization service identifies a major medical condition, that condition will be subject to case management review. Case management review aims at identifying major medical conditions early in the treatment plan and makes recommendations regarding the medical necessity of requested health care services.

Case managers with experience in intensive medical treatment and rehabilitation provide case management services. The case manager works with the patient's physician to identify available resources and develop the best treatment plan.

In addition, the case manager can coordinate the various caregivers, such as occupational or physical therapists, required by the patient. Situations that may benefit from case management include severe illnesses and injuries such as:

- Head trauma
- Organ transplants
- Burn cases
- Neo-natal high risk infants
- Multiple fractures
- HIV-related conditions
- Brain injuries
- Cancer
- Prolonged illnesses
- Degenerative neurological disorders (e.g. multiple sclerosis).

To best help the patient, the case managers should be involved from the earliest stages of a major condition. This service gives you access to a knowledgeable case manager who will use his or her expertise to assist you and your physician in considering your treatment options.

If the case managers questions the necessity of the proposed hospital admission or procedure, a physician advisor may contact your physician to discuss your case and suggest other treatment options that are generally utilized for your condition. Your physician may also be asked to adhere to Aetna's evidence-based treatment protocols

when treating oncology patients. You, your physician, and the case manager will be informed of the outcome of the review, and the Claims Administrator will determine the level of benefit coverage you will receive. You and your physician will be notified of the utilization reviewer's recommendation by telephone and in writing. You will also be informed of the appeal process if the procedures your physician ultimately recommends are not covered under the Plan (as determined by the Claims Administrator).

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for pre-existing conditions for you or any covered family members.

Are immunizations for business travel covered under the Plan?

The Plan does not cover immunizations for business travel.

Is acupuncture covered under the Plan?

The Plan covers acupuncture when it is:

- performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan.
- a form of Alternative Treatment as long as it is rendered by a certified/licensed individual.

Coverage is limited to 30 visits per year.

Are insulin pump supplies covered under the medical coverage?

Yes. Insulin pump supplies are covered under the medical and prescription drug coverage. Any disposable syringes used in conjunction with insulin pump treatment would be covered under the prescription drug benefits.

Can a prosthetic device be replaced?

The Plan covers the replacement of prosthetic devices when medically necessary. The Plan does not cover replacements due to loss or misuse.

Are wigs covered?

The Plan will pay benefits for wigs when medically necessary up to a maximum of $300 per calendar year per covered member

Preventive/Wellness Care

How is preventive/wellness care covered?

The Plan covers Preventive/Wellness Care at:

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

If covered as part of annual physical, routine hearing screenings performed by a PCP (such as whispered voice, tuning fork), which do not utilize calibrated instruments, covered at 100% with no cost sharing in network.

What services are considered preventive/wellness care?

The Plan considers physician, testing and diagnostic fees for the following specific wellness expenses to be preventive/wellness care:

- Blood cell counts
- Blood tests for prostate screening
- Breastfeeding support, including education for mothers and families as well as direct support for mothers during breastfeeding provided by a certified lactation support provider. Purchase/rental of breast pumps and supplies are subject to THIRD PARTY ADMINISTRATOR limitations.
- Colorectal cancer testing for average-risk members aged 45 years and older
- Cholesterol tests
- Mammograms (including 3D mammograms)
- Pap smears
- Routine physical exams, including one pelvic exam each calendar year
- Sigmoidoscopy (covered if you are 45 and over.)
- Tuberculosis tests
- Urinalysis.

The following services are not considered preventive/wellness care:

- Services which are covered to any extent under any other group plan of your employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a hospital or other facility for medical care.

- Services which are not given by a physician or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment or required by a third party such as school or camp.
- Premarital exams.
- Vision, hearing, or dental exams.

Does the Plan cover outpatient physician services?

The Plan covers charges for outpatient office visits at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Does the Plan cover gynecology visits?

The Plan covers one routine gynecological exam each calendar year at:

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers under after the Plan deductible has been met.

Does the Plan cover mammograms?

The Plan covers routine mammograms (including 3D mammograms) at:

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

There are no age or frequency limitations. It is recommended that members follow the American Cancer Society guidelines for age and frequency to determine when to receive preventive care services.

Does the Plan cover Pap smears?

The Plan covers one routine Pap smear each calendar year at:

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine Pap smear as a follow-up to a medical diagnosis, the Plan:

Under the $1,500 Deductible Plan

- covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- covers your Pap smear at 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover prostate specific antigen (PSA) tests and routine Annual Digital Rectal exams?

The Plan covers routine prostate specific antigen (PSA) tests for covered males (with no age limitations) and routine Annual Digital Rectal Exam (DRE).

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine DRE test as a follow-up to a medical diagnosis, the Plan covers your DRE test at:

Under the $1,500 Deductible Plan

- 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Maternity

Who is eligible for maternity coverage?

Maternity coverage is available to eligible covered female participants.

Do I need to have my maternity coverage preauthorized?

No. Preauthorization within 48 hours is not required for the initial hospital admission.

You must notify the preauthorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

Does the Plan cover prenatal visits?

Note that routine prenatal care, as defined by the Department of Health and Human Services, is covered with no cost sharing (i.e. deductibles, coinsurance) for all plans.

The Plan covers prenatal visits in-network at:

Under the $1,500 Deductible Plan

- 80% for IN-NETWORK PROVIDERS after the Plan DEDUCTIBLE has been met; first visit only.

Under the $3,000 Deductible Plan

- 70% for in-network providers after the Plan deductible has been met; first visit only.

After the first visit, subsequent visits are typically billed as part of doctor's delivery fee, which is also reimbursed at:

Under the $1,500 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% after the Plan's deductible has been met.

The Plan covers prenatal visits out-of-network at:

Under the $1,500 Deductible Plan

- 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for delivering the baby?

The Plan covers charges for delivery of the baby at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for examining the baby?

The Plan covers the charges for your baby's first examination in the hospital at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

What will the Plan pay for hospital charges for the mother and the baby?

The Plan covers hospital charges for maternity admissions at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

The Plan covers newborn nursery care at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

The mother and the newborn child are covered for a minimum of 48 hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may — after consulting with the mother — discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean section).

You must notify the Claims Administrator within 24 hours of a determination to extend the stay.

Newborn expenses, including nursery charges in the hospital, will apply to a newborn's individual deductible under the $3,000 Deductible Plan. Under the $1,500 Deductible Plan, newborn expenses, including nursery charges in the hospital, will apply to the family deductible.

Does the Plan cover midwife services?

The Plan covers midwives who are in practice with a network group at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

What is the wellness program for Maternity?

The Aetna Enhanced Maternity™ Program provides tools and information to help your whole family have a successful pregnancy. Use this program throughout your pregnancy and after your baby is born to:

- Learn what's best for a healthy pregnancy
  - Receive materials on prenatal care, labor and delivery, newborn care and more
  - Get information for the father or domestic partner
  - Take a pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy
- If you have issues or risk factors that need special attention, the program's nurses provide personal case management to determine ways to lower your risks
- Access to genetic counseling (by phone) with board-certified genetic counseling experts
- Get support to help quit smoking
- Reduce your risk for pre-term labor.

For more information, call the Aetna Enhanced Maternity™ Program at +1 800 CRADLE1 (+1 800 272 3531).

If my dependent child has a baby does the Plan cover the newborn child?

Unless the newborn meets the definition of an eligible child and is covered under the Plan, medical care for the newborn, whether in or out of the hospital, is not covered.

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments with a benefit cap of $20,000 for medical services and a separate benefit cap of $20,000 for pharmacy services at:

Under the $1,500 Deductible Plan

- 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Benefits for infertility treatment are limited to a medical lifetime maximum of $20,000 per person.

Infertility treatments are covered as follows:

- Assisted reproduction procedures (including facility charges and related expenses) due to infertility
- Ovulation induction and monitoring
- Artificial Reproductive Technology (ART)
  - In vitro fertilization
  - Gamete intrafallopian transfer (GIFT)
  - Zygote intrafallopian transfer (ZIFT)
  - Cryopreserved embryo transfers
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Medically necessary fertility preservation and cryopreservation for individuals who are presumed to be fertile but who have planned therapies for the treatment of medical conditions
- Pre-implantation genetic screening (PGT-A/PGS)

Artificial insemination is considered an infertility treatment and is limited to the overall infertility medical lifetime maximum of $20,000 per person as noted in the infertility treatment sub-section.

You must obtain preauthorization before receiving infertility treatment.

Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.

Is there a program for help navigating the fertility process?

Aetna's National Infertility Unit (NIU) is part of Aetna's women's health programs. NIU provides education around fertility treatment options, helps members through the preauthorization process and directs members to quality providers.

You need to enroll in the program once there is a plan for infertility treatment. This includes ovulation induction with injectable infertility medications, artificial insemination or assisted reproductive technology (ART). You do not need to register in the NIU program in order to see a physician to determine why you are having trouble getting pregnant, or to start orally medicated, timed intercourse cycles.

If you plan to start treatment for infertility, log in to Aetna's website to complete the registration form or call +1 800 575 5999.

Are contraceptive devices covered under the Plan?

The Plan covers contraceptive devices under the medical plan at:

Under the $1,500 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 100% for in-network providers (no deductible) and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Certain contraceptives are covered under the prescription drug plan including oral and injectable contraceptives as well as contraceptive devices.

To check drug coverage, visit www.caremark.com.

Does the Plan cover vasectomy?

The Plan covers vasectomies at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Vasectomy reversals are not covered under the Plan.

Does the Plan cover tubal ligation?

The Plan covers in-patient and outpatient tubal ligation at:

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Tubal ligation reversals are not covered.

Gender Reassignment Surgery

Does the Plan cover gender reassignment surgery?

Gender reassignment surgery is covered for persons that meet all of the following conditions:

- You are at least 18 years old
- You have been diagnosed with Gender Dysphoria.
- Preauthorization is required. Contact the Claims Administrator for specific details.

What gender reassignment surgery benefits will the Plan pay?

The Plan will provide medically necessary benefits in connection with gender reassignment surgery, including:

- Hair removal, such as electrolysis, laser treatment, etc.
- Tracheal shave/reduction
- Facial feminization surgeries
- Voice modification surgeries
- Voice modification therapy
- Lipoplasty/filling for body masculinization or feminization

Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan.

Inpatient Hospital and Physician Services

What will the Plan pay if I have to go to the hospital?

The Plan pays inpatient hospital charges at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

The Plan will cover the cost of a semi-private room. If you use a private room, the Plan will cover the amount up to the semi-private room rate.

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital stay.

What approvals do I need if I am going into the hospital?

Preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a physician at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover ambulance charges?

The Plan covers transportation by ambulance to a medical facility at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 70% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Coverage includes charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital and the above two conditions are met.

Does the Plan cover hospice care?

The Plan covers charges for hospice at:

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $3,000 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you receive hospice care.

Cardiac Care

Aetna's Centers of Excellence, known as Institutes of Quality (IOQ) for Cardiac care is a special network of hospitals and other facilities known for quality care. Aetna's Cardiac IOQ facilities specialize in the following cardiac procedures: Rhythm (electrophysiology, ablation, pacemakers, defib); interventional (heart cath, PTCA - balloon opening artery of heart, stent); and surgery (CABG, valve with CABG, valve without CABG).

If you utilize a Cardiac IOQ, your INPATIENT surgery will be covered at 100% after the plan's in-network DEDUCTIBLE. Prior authorization is required.

	$1,500 Deductible Plan	$3,000 Deductible Plan
Tier 1: Cardiac Center of Excellence (IOQ)	Covered at 100% after deductible	Covered at 100% after deductible
Tier 2: In-Network	You pay 20% after deductible	You pay 30% after deductible
Tier 3: Out-of-Network	You pay 40% after deductible	You pay 50% after deductible

See Travel and Lodging section for information about reimbursement for travel and lodging expenses related to cardiac care.

The maximum reimbursement for all travel and lodging expenses is $10,000 per episode of care.

Massage Therapy

Does the Plan cover massage therapy services?

Yes, the Plan covers massage therapy services only as part of a Chiropractic Care or Physical Therapy treatment program.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

Yes, the Plan covers mastectomy-related services. Coverage will be provided in a manner determined by the attending physician and the patient. The covered services include:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,

- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

What are the applicable deductibles and coinsurance for mastectomy-related benefits under the Plan?

The mastectomy-related benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. See the "Detailed List of Covered Services" on page 49 for the applicable mastectomy – reconstructive surgery coverage.

Musculoskeletal Surgery – Knee, Hip, Spine

Aetna's Centers of Excellence, known as Institutes of Quality (IOQ) for Orthopedic is a special network of hospitals and other facilities known for quality care. Aetna's IOQ facilities specialize in:

- Spine surgery - (laminectomy, primary fusion, fusion revision, discectomy (w/out decompression), decompression (w/out fusion)
- Total joint replacement (knee/hip)

If you utilize an IOQ, your surgery will be covered at 100% after the plan's in-network DEDUCTIBLE. Prior authorization is required.

	$1,500 Deductible Plan	**$3,000 Deductible Plan**
Tier 1: Center of Excellence (IOQ)	Covered at 100% after deductible	Covered at 100% after deductible
Tier 2: In-Network	You pay 20% after deductible	You pay 30% after deductible
Tier 3: Out-of-Network	You pay 40% after deductible	You pay 50% after deductible

See Travel and Lodging section for information about reimbursement for travel and lodging expenses related to musculoskeletal surgery.

Obesity Surgery

The plan covers surgical treatment of obesity provided by or under the direction of a physician. Coverage is limited to once per person per lifetime.

Prior authorization under the condition of meeting the medical definition of morbid obesity is required. All services, including surgery, must be obtained from a recognized in-network Institute of Quality (IOQ). Contact the Claims Administrator for specific details on requirements and how to find a facility.

See Travel and Lodging section for information about reimbursement for travel and lodging expenses related to obesity surgery.

Occupational Therapy

The plan covers the treatment to:

- Learn or re-learn daily living skills (e.g., bathing, dressing and eating) or compensatory techniques to improve the level of independence in the activities of daily living
- Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease.

Coverage includes services, treatment, education testing or training related to developmental delays.

Prior authorization for occupational therapy is recommended. Contact the Claims Administrator for specific details. Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Orthognathic Coverage

The Plan covers the diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite), and jaw alignment. Prior authorization is required. Contact the Claims Administrator for specific details.

See “What’s Not Covered” on page 59 for orthognathic coverage exclusion.

Physical Therapy

The plan covers evaluation and treatment by physical means or modalities that:

- Follows a specific treatment plan prescribed by your physician and is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure

Coverage includes services related to developmental delays.

Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Sword Health Virtual Physical Therapy

The plan covers the virtual treatment of acute, chronic, pre-surgical and post-surgical pain at home combining an exercise program prescribed by licensed physical therapists with motion sensor technology.

- Areas of focus include back, shoulder, neck, knee, elbow, hip, ankle, wrist and pelvic area.
- A physical therapist designs an exercise program based on the specific treatment prescribed by a physician. Sword Health will ship you a tablet and wearable motion sensors which will provide real-time feedback during your exercises. You then complete your exercise sessions at home when it is convenient for you. Your physical therapist is there to support you virtually and is available for chat via the Sword Health mobile app.

- Physical therapy sessions are unlimited per month.
- Virtual physical therapy typically consists of an initial period of 8-12 weeks. Sessions are usually 20-30 minutes and it is recommended that you complete sessions three to five days per week.
- A check-in between a member and a physical therapist is typically twice a week via chat or email. Video calls take place every four weeks. Members can also speak to their physical therapist via phone calls if they choose to exchange personal phone numbers.

Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Sword Health Virtual Physical Therapy includes a Digital Therapist© tablet, motion sensors, straps and support from a licensed physical therapist. Access the Sword Health mobile app is also included which provides for direct chat with the dedicated physical therapist and access to educational articles. The Sword Health mobile app is available in the App Store for iOS devices and on Google Play for Android devices.

You must be 18 years of age or older and enrolled in the $1,500 or $3,000 DEDUCTIBLE Plans administered by Aetna to use Sword Health Virtual Physical Therapy.

The cost to utilize Sword Health Virtual Physical Therapy is subject to the medical plan (plan deductible and COINSURANCE for the $1,500 or $3,000 Deductible Plans) you are enrolled in. The cost structure for Sword Health Virtual Physical Therapy works differently from the other physical therapy services covered under the plan - services are subject to a monthly cost share. For information on the actual cost for these services, refer to the “Detailed List of Covered Services” on page 49.

For more information and to start virtual physical therapy, go to join.swordhealth.com/mm/.

Note: Sword Health is an available option for physical therapy under the plan. It is not the only option. For an alternative option, see the Physical Therapy section above.

Prescription Drugs

How does the Plan cover prescription drugs?

Prescription drugs are covered as follows:

Prescription drugs	There is a CVS Caremark® Retail Pharmacy Network for 30-day supply (acute) and CVS Caremark® Retail and CVS Caremark® Mail Order for 90-day supply (maintenance) prescription drugs.	
	$1,500 Deductible Plan	**$3,000 Deductible Plan**
Retail Prescriptions (30-day supply)		
▪ Generic	80% COINSURANCE after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
CVS Caremark® Retail and CVS Caremark® Maintenance Choice Program Mail-order Prescriptions (90-day supply)		
▪ Generic	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	80% coinsurance after deductible	70% coinsurance after deductible
Prescription Drug Programs	There are prescription drug programs available as part of the medical plan options. For information on Rx Savings Solutions, Transform Diabetes® Care, WW Digital Program and Hello Heart, refer to “Prescription Drug Programs” on page 41.	

Does the Plan cover formulary and non-formulary brand-name prescription drugs?

The Plan covers formulary and non-formulary prescription drugs purchased via the Plan’s mail order service or a participating retail pharmacy. The prescription drugs in the formulary may change. Select medications may be excluded from coverage (this list may be updated periodically).

To price medications and check formulary, visit www.caremark.com.

Unless your physician specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

Does the Plan cover generic drugs?

The Plan covers generic prescription drugs purchased via the Plan's mail order service or at a retail pharmacy.

What happens if I buy a brand-name prescription drug when a generic drug is available?

Unless your physician specifically prescribes a brand name medicine without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available and there is no medical reason for the brand-name prescription drug, you pay your share of the cost for the generic drug in addition to the difference between the brand-name prescription drug and generic prescription drug gross cost. The difference in cost between the brand-name prescription drug and generic prescription drug does not accumulate towards your deductible and out-of-pocket maximum. If you meet your out-of-pocket maximum, you will continue to pay the difference in cost between the brand-name prescription drug and generic prescription drug.

How does the Plan cover generic and brand-name contraceptive medications with no generic equivalent?

The Plan will cover certain generic and brand-name contraceptive medications with no generic equivalent at 100% in-network with no cost sharing as long as a valid prescription is submitted.

What is the Plan coverage for preventive drugs?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $1,500 Deductible Plan and $3,000 Deductible Plan are covered with no cost sharing (i.e. deductible, coinsurance, copay). Certain examples include: aspirin products, fluoride products, folic acid products, immunizations, contraceptive methods, smoking cessation products, bowel preps, primary prevention of breast cancer and statins. The list of preventive medications covered with no cost sharing, called the CVS Caremark ACA Drug List, is subject to periodic review and many change.

If you enrolled in the $1,500 Deductible Plan or the $3,000 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs. This list of preventive medications, called the CVS Caremark Preventive Drug List, is covered at the standard coinsurance and the list of medications is subject to periodic review and change.

Call CVS Caremark® at +1 844 449 0362 for more information about preventive drugs. You can access the preventive drug listing at www.caremark.com. To obtain information on the cost of preventive drugs, log on to the Drug Cost Tool at www.caremark.com. Follow the provided steps to access the Drug Cost Tool.

- Log on to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Check Drug Cost & Coverage.
- Enter drug name & dose and choose a pharmacy.

The Prescription Drug Benefits Manager provides an online directory of network pharmacies available at www.caremark.com.You may also call the Prescription Drug Benefits Manager.

Is there a mail-order program?

The Plan's mail order service allows participants to order up to a 90-day supply of prescription medication by mail for certain maintenance medications. You may also obtain a 90-day supply of maintenance medications at CVS Caremark® retail pharmacies. Using the CVS Caremark® Maintenance Choice program mail order service or obtaining a 90-day supply of maintenance medications will generally cost you less than using a non-CVS Caremark® retail pharmacy.

If I buy more than three fills of a prescription drug at a retail pharmacy, will I have to pay more?

In addition to mail order, you will be able to fill a 90-day supply of your maintenance medications at a CVS Caremark® retail pharmacy, at the same cost as you would through the CVS Caremark® Maintenance Choice mail order program. For all maintenance medications, after the first three fills, you must fill a 90-day supply either at CVS Caremark® Retail pharmacy or through CVS Caremark® Maintenance Choice Mail Order service. After three fills, the next fill for a 30-day supply or filled at a non-CVS Caremark® Retail pharmacy or not through CVS Caremark® Maintenance Choice Mail Order will reject. You will pay 100% of the full cost for all subsequent fills. Amounts you pay for rejected claims will not accumulate towards the deductible and out-of-pocket maximum.

If I purchase a specialty medication at retail, will the prescription be covered?

If a specialty medication is filled at a non-CVS Caremark® retail pharmacy, the prescription will not be covered and amounts you pay for the not covered prescription will not accumulate to the out-of-pocket maximum.

Are any prescription drugs or drug supplies subject to limitations?

You may be subject to several different types of drug management programs. These include quantity management, prior authorization and qualification by history or step therapy.

Quantity Management

To ensure safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer and/or clinically approved guidelines and are subject to periodic review and change.

Select examples of drug categories include:

- Antiemetic agents
- Antifungal agents
- Erectile dysfunction agents
- Migraine therapy
- Narcotic analgesics
- Non-narcotic analgesics
- Specialty medications

Prior Authorization

Certain medical treatments and prescription medicines need prior approval (which may include the submission of clinical information by your prescriber) before the Plan will cover them. This requirement is to ensure the treatment or medication is appropriate and effective. If you do not receive approval, you will be responsible for paying the full cost.

Select examples of drug categories include but are not limited to:

- Androgens and anabolic steroids
- Anorexiants
- Antinarcoleptics
- Dermatologicals
- Specialty medications – require prior authorization under the Plan and are subject to quantity limitations as well
  - Examples of drug categories include: Cancer therapies, Growth Hormones, Hepatitis, Immune Globulins, Multiple Sclerosis, Myeloid Stimulants, Psoriasis, Pulmonary Arterial Hypertension (PAH), Rheumatoid Arthritis, RSV agents.

The drugs that require prior authorization may be modified. To obtain prior authorization for coverage ask your doctor to call CVS Caremark® at +1 800 237 2767. After they receive the necessary information, you and your doctor will be notified confirming whether or not coverage has been approved.

Qualification by History (Step Therapy)

Some medications require the trial of another drug and/or require certain criteria such as age, or condition (determined by previous claims history) to receive coverage. In these cases, a coverage review will be required if certain criteria cannot be determined from past history.

Select examples of drug categories include:

- Cardiovascular agents
- COX-II Inhibitors
- Dermatologicals
- Migraine therapy
- Osteoporosis agents

The drugs that may become subject to qualification by history rules may be modified.

Contact the Prescription Drug Benefits Manager at +1 844 449 0362 for more information about any of these programs.

Are there any limitations on specialty prescription drugs?

Specialty medications may require prior authorization under the Plan and may be subject to quantity limitations and cost caps. These limits are subject to change and are discussed above.

Certain specialty drugs which you can administer to yourself (or a caregiver may administer to you) may not be covered under the medical benefit. These drugs must be obtained at CVS Caremark's® Specialty Pharmacy.

Contact the Prescription Drug Benefits Manager at +1 844 449 0362 for more information about any of these programs.

Medical Specialty Drugs Administered by a Medical Provider

Your Plan covers certain Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting or in your home by a home infusion provider.

Precertification

Precertification is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your Provider will submit clinical information which will be reviewed for decision.

For a list of Medically Administered Specialty Drugs that need precertification, please contact your Claims Administrator. The precertification list is reviewed and updated from time to time. Including a Specialty Drug on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator to verify Specialty Drug coverage, to find out which drugs are covered under this section and if precertification is required.

If you are receiving an infused medication, certain medications may require use of the lowest cost site of care.

What prescription drugs and drug supplies are excluded from prescription drug coverage?

The following drugs and drug supplies are excluded from prescription drug coverage:

- Over-the-counter drugs (including topical contraceptives, nicotine products, vitamins and minerals, nutritional products including enteral products and infant formulas, homeopathic products and herbal remedies). Certain drugs will be covered with a prescription under Health Care Reform.
- Medical equipment and devices – insulin pumps, insulin pump syringes
- Home diagnostic kits
- Certain injectables (i.e. IV infused)
- Allergy serums
- Plasma and blood products
- Drugs for cosmetic use
- Investigational drugs, experimental use drugs, non-FDA approved drugs and compounds.
- Arestin

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan administered by CVS Caremark®. You may use a pharmacy in the network as well as out-of-network to receive coverage under this Plan.

Note that when you go to a pharmacy that's out-of-network, you need to submit a claim form for reimbursement. Refer to "How do I file a prescription drug claim form?" on page 69 for more information.

The Prescription Drug Benefits Manager provides an online directory of network pharmacies available at www.caremark.com.

To locate an in-network retail pharmacy:

- Go to www.caremark.com.
- Login or create an account.
- Plan & Benefits.
- Pharmacy Locator.

Or call CVS Caremark® at +1 844 449 0362 for more information.

How do I file a claim for benefits for prescription drugs?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable deductible or coinsurance. Rarely will you need to file a claim with the Prescription Drug Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). To file a claim, contact the Prescription Drug Benefits Manager.

Claim forms are available on the Prescription Drug Benefits Manager's website. Should you need to file a claim, you are reimbursed for the contracted rate less coinsurance. You have 12 months from the date the expense was incurred to submit a claim.

Is there a separate ID card for the prescription drug program?

Yes, there is a separate ID card for the prescription drug program. If you are enrolled in medical coverage, you will automatically be sent a prescription drug ID card in addition to your medical plan ID card. You will be sent two prescription ID cards. If you enroll one or more family member, each prescription ID card will list the names of all covered family members.

You may request additional ID cards directly from the Prescription Drug Benefits Manager or by printing online at www.caremark.com.

There is a separate ID card for medical coverage. For information on medical plan ID cards, refer to the ID cards section.

Prescription Drug Programs

Rx Savings Solutions

Rx Savings Solutions is a program and tool to identify cost savings opportunities for prescriptions. Rx Savings Solutions sends proactive, personalized recommendations when an opportunity to save money on a prescription medication is identified. This

means that if a lower cost alternative exists for a medication you may be taking (e.g. same medication in a slightly different dose, or a different medication that may work similarly to the one prescribed), Rx Savings Solution will alert you that another medication option is available. This benefit is available to all members who participate in any of the Aetna medical plan options and CVS Caremark® prescription drug plan at no cost to you.

When you receive a recommendation from Rx Savings Solutions, you have the option to talk to your prescriber about changing your prescription, have Rx Savings Solutions assist you by using the Contact Prescriber feature described below, or stay with your initial prescription.

Rx Savings Solutions will send personalized notifications by email (or text message, if you enroll in this service) whenever savings opportunities are found. You may also view savings opportunities from a personal dashboard through the Rx Savings Solutions member portal at https://mmc.rxsavingssolutions.com, as well as those for enrolled family members.

Rx Savings Solutions also offers the following features:

- Medicine Cabinet - a list of medicines a member is taking
- Medication Reminders - reminders for members to take their medication to promote adherence
- Contact Prescriber – members can use the “Contact Prescriber” option to have Rx Savings Solution call the member’s prescriber to assist the member in getting a new prescription. It automates the process of changing prescriptions when a member decides to take advantage of a savings opportunity (participation is optional).

Call Rx Savings Solutions at +1 800 268 4476, Monday to Friday, 8:00 am to 9:00 pm Eastern Time or visit https://mmc.rxsavingssolutions.com for more information.

Transform Diabetes® Care Program

Transform Diabetes Care offers care for you and your eligible family members age 18 years of age and older enrolled in the $1,500 or $3,000 Deductible Plans administered by Aetna who’ve been diagnosed with diabetes. This program is available at no cost to you and your eligible family members. If you’re diagnosed with diabetes, you’re automatically enrolled. All eligible members will receive communication in the mail with instructions on how to enroll and use the program.

As a part of this program, you and your eligible family members will receive individualized support across five clinical impact areas:

- Glucose and blood pressure monitoring including no cost diabetes test strips (if eligible based on your individual needs and a review from a trained diabetes educator).
- Lifestyle and comorbidity management
- Medication optimization

- Preventative screenings
- Medication adherence

The program provides coaching support from a health coach and a Certified Diabetes Nurse.

Who is Eligible for the Transform Diabetes Care Program?

Members diagnosed with diabetes age 18 years of age and older who are enrolled in the $1,500 or $3,000 Deductible Plan administered by Aetna with prescription drug coverage through CVS Caremark®.

If you have any questions about eligibility, you may contact CVS Caremark® at +1 844 449 0362.

Hello Heart Program

Hello Heart provides care and support to you and your eligible family members age 18 years of age and older enrolled in the $1,500 or $3,000 Deductible Plans administered by Aetna who've been diagnosed with hypertension. This program is available at no cost to you and your eligible family members. All eligible members will receive communication in the mail with instructions on how to enroll and use the program.

The program provides digital remote blood pressure monitoring. As part of Hello Heart program, you will receive the following:

- Access to the Hello Heart mobile application that includes digital coaching and support aimed at improving heart health
- Hello Heart blood pressure monitor.

If you qualify, you'll receive a blood pressure monitor. You'll have the ability to register for the program via Hello Heart's online portal and download the Hello Heart application to your mobile device, for access to additional tracking tools and resources for heart health.

Who is Eligible for the Hello Heart Program?

Members diagnosed with hypertension who are 18 years of age and older and enrolled in the $1,500 or $3,000 Deductible Medical plans administered by Aetna with prescription drug coverage through CVS Caremark®.

If you have any questions about eligibility, you may contact CVS Caremark® at +1 844 449 0362 or Hello Heart at + 1 800 767 3471.

WW Digital Program

The WW Digital Program provides science-based tools to help you and your eligible family members 18 years of age or older enrolled in the $1,500 or $3,000 Deductible Plans administered by Aetna lose weight, eat healthier, move more, and develop a more positive mindset. The program is available at no cost to you and your eligible family members.

WW Digital includes:

- PersonalPoints™ Plan
- Access to a mobile application that includes digital tools:
  - Trackers for food, water, physical activity, sleep and weight
  - Recipes
  - Meal planning tools
  - On-demand workouts
  - Support from WW's community of members

Who is Eligible for the WW Digital Program?

Members who are 18 years of age and older and enrolled in the $1,500 or $3,000 Deductible Plans administered by Aetna with prescription drug coverage through CVS Caremark®.

If you have any questions about the program, you may contact CVS Caremark® at +1 844 449 0362 or WW Customer Care at +1 866 204 2885. To learn more or enroll, visit WW.com/MarshMcLennan.

Mental Health/Substance Use

Does the Plan cover mental health/substance use services?

The Plan covers medically necessary inpatient and outpatient mental health/substance use treatment services, including residential treatment.

Does the Plan cover services in connection with autism?

The Plan covers medically necessary inpatient and outpatient treatment services for autism. The Plan will cover certain early intensive behavioral interventions such as applied behavioral analysis (ABA) where the intervention is applied to systematically change behavior and the intervention is responsible for observable improvements in behavior. ABA requires prior authorization.

Speech Therapy

The plan covers the treatment of:

- A speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly
- Delays in speech development.

Prior authorization for speech therapy is recommended. Contact the Claims Administrator for specific details. Ongoing therapy is subject to periodic clinical review to determine medical necessity for continued therapy.

Temporomandibular Joint (TMJ) Coverage

The Plan covers services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by and under the direction of a physician. Coverage includes the diagnostic or surgical treatment required as a result of an accident, trauma, congenital defect, developmental defect or pathology.

- Diagnostic coverage includes examination, radiographs and applicable imaging studies, and consultation.
- Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Surgical treatment* includes arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants.

  *Surgical treatment is provided if the following criteria are met:

  - There is clearly demonstrated radiographic evidence of significant joint abnormality.
  - Non-surgical treatment has failed to adequately resolve the symptoms.
  - Pain or dysfunction is moderate or severe.

See “What’s Not Covered” on page 59 for TMJ exclusions.

Travel and Lodging

As described below, the Plan will reimburse you for certain amounts paid for:

- Transportation primarily for, and essential to, medical care and
- Lodging while away from home if a principal reason for being there is to receive medical care.

Expenses for travel to and from your home and lodging will be reimbursed:

- For cardiac care covered services (see “Cardiac Care”) received at an Aetna Institute of Quality (IOQ) if the IOQ is 100 miles or more from the patient’s home

- For cardiac care covered services received at another facility if no in-network provider is available within 100 miles of the patient's home
- For musculoskeletal surgery (see "Musculoskeletal Surgery – Knee, Hip, Spine") received at an Aetna Institute of Quality (IOQ) if the IOQ is 100 miles or more from the patient's home
- For musculoskeletal surgery received from another facility if no in-network provider is available within 100 miles of the patient's home
- For obesity surgery received at an Aetna Institute of Quality (IOQ) (see "Obesity Surgery") if the Institute of Quality is 100 miles or more from the patient's home
- For solid organ and bone marrow transplants received at an Aetna Institute of Quality (IOQ) if the IOQ is 100 miles or more from the patient's home
- For solid organ and bone marrow transplants received from another provider if no in-network provider is available within 100 miles of the patient's home
- For all other covered services under the Plan (see "What's Covered") if no in-network provider is available within 100 miles of the patient's home.

What is the Plan's travel expense benefit?

The Plan will reimburse amounts paid for transportation primarily for, and essential to, medical care, as described above under "Travel and Lodging". These include:

- Bus, taxi, train, or plane fares or ambulance service
- Transportation expenses of a parent who must go with a covered child who needs medical care
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone and
- Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.

When you use a car for medical reasons, the Plan will reimburse

- Parking fees and tolls and
- Car expenses determined either by
  - The amount of actual out-of-pocket car expenses, such as the cost of gas and oil or
  - The standard IRS medical mileage rate in effect when you travel if you don't want to use your actual expenses. Go to www.irs.gov and enter "standard mileage rate" in the "Search" box for more information.

Note: the Plan will *not* reimburse depreciation, insurance, general repair, or maintenance expenses.

What is the Plan's lodging expense benefit?

The Plan will reimburse the cost of lodging at a hospital or similar institution if a principal reason for being there is to receive medical care under the circumstances described above under "Travel and Lodging". The Plan will reimburse the cost of lodging not provided in a hospital or similar institution if all the following requirements are met:

- The lodging is primarily for and essential to medical care.
- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.
- The lodging isn't lavish or extravagant under the circumstances.
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The Plan does not reimburse the cost of meals.

Is there a limit on the travel and lodging expense benefit the Plan will reimburse?

The reimbursement for lodging expenses is limited to $50 per night per person, including lodging expenses of a parent who must go with a child who needs medical care or of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone. The maximum reimbursement for lodging expenses is $100 per night.

The maximum reimbursement for all travel and lodging expenses combined is $10,000 per episode of care.

How can participants receive reimbursement from the Plan?

Contact the Claims Administrator for information.

Important Information About Your Personal Health Information

- The Company does not collect, maintain, or report on any personal health information pertaining to you or any covered dependents.
- As a participant in our health plan, your personal health information is protected by federal law.
- Our medical Third Party Administrators (or carriers with respect to the insured programs) are required to protect your personal health information in accordance with federal law and data privacy agreements with the Company and/or plan fiduciaries.
- Please note that states seeking to prohibit or limit certain services covered under Company-sponsored plans might attempt to challenge your right to privacy under federal law. If a state's legal challenge is successful, there may be legal consequences associated with you procuring a service covered under a Company-sponsored plan that is or may become prohibited or limited under state law. If you have any questions regarding potential risks, please seek professional legal advice.

Virtual Medicine

What is Teladoc?

Teladoc lets you talk to a US board-certified doctor through your mobile device or a computer with a webcam. The doctor can diagnose, recommend treatment and prescribe medication, when appropriate, for many medical issues. You can use this service for common health concerns like colds, the flu, fevers, rashes, infections, allergies, etc. Teladoc also provides services for Psychology and Psychiatry.

When is Teladoc available?

Doctors are available on Teladoc 24/7, 365 days a year.

How does Teladoc work?

When you need to see a doctor, go to Teladoc.com/Aetna or access the Teladoc mobile app to set up an account. Establishing an account allows you to securely store your personal and health information. Once connected, you can talk and interact with the doctor.

If you are using Teladoc for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future online visits.

Do doctors have access to my health information?

Doctors can only access your health information and review previous treatment recommendations and information from your prior Teladoc visits.

How do I access the Teladoc mobile app?

You can download the mobile app for free on your mobile device by visiting the App Store or Google Play.

How do I pay for the online doctor's visit?

Teladoc accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Prescriptions aren't included in the cost of your doctor's visit.

Can I get online care from a doctor if I'm traveling or in another state?

If you are located in a state where Teladoc is available, you can get online care. To determine if online visits with a doctor are available in your state, visit Teladoc.com/Aetna and view the state map at the bottom of the home page.

Who do I contact for additional information?

You can call +1 855 Teladoc (+1 855 835 2362)

Detailed List of Covered Services

The Plan reimburses medically necessary covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered and determines the amount to be reimbursed.

The covered services listed are the same under the Broad Network and the Narrow Network.

Most services and supplies are subject to a deductible and coinsurance.

Your costs for out-of-network services apply toward the in-network deductible and out-of-pocket maximum. However, your costs for in-network services do not apply toward the out-of-network deductible and out-of-pocket maximum.

$1,500 Deductible Plan and $3,000 Deductible Plan

	$1,500 Deductible Plan		**$3,000 Deductible Plan**	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance use	***Inpatient and Residential Treatment:*** 80% after deductible Preauthorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Preauthorization is required ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment:*** 70% after deductible Preauthorization is required ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment:*** 50% of R&C after deductible Preauthorization is required ***Outpatient:*** 50% after deductible
Allergy testing and treatment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Alternative medicine (Acupuncture)	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
	Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 30 visits per calendar year (combined in-network/out-of-network).		Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 30 visits per calendar year (combined in-network/out-of-network).	
Ambulance charges	80% after deductible	80% of R&C after deductible	70% after deductible	70% of R&C after deductible

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Applied Behavioral Analysis (ABA)	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	70% after deductible Preauthorization is required	50% of R&C after deductible Preauthorization is required
Artificial insemination	80% after deductible Limited to overall infertility maximum of $20,000* per lifetime (combined in-network/out-of-network) Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.	60% of R&C after deductible Limited to overall infertility maximum of $20,000* per lifetime (combined in-network/out-of-network) Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.	70% after deductible Limited to overall infertility maximum of $20,000* per lifetime (combined in-network/out-of-network) Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility	50% of R&C after deductible Limited overall infertility maximum of to $20,000* per lifetime (combined in-network/out-of-network) Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.
CT / PET scans	80% after deductible. CT/PET scans subject to preauthorization	60% of R&C after deductible. Medical Necessity Required.	70% after deductible. CT/PET scans subject to preauthorization	50% of R&C after deductible. Medical Necessity Required.
Chiropractors	80% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	60% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network	70% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	50% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%, without deductible	60% of R&C after deductible	Covered at 100%, without deductible	50% of R&C after deductible
Cosmetic surgery	Not covered	Not covered	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound teeth within 12 months)	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Durable medical equipment (DME)	80% after deductible Preauthorization is required for purchase or rentals of certain DME	60% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME	70% after deductible Preauthorization is required for purchase or rentals of certain DME	50% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME
EKG Testing	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	60% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	50% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.
Emergency room	80% after deductible for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 71).	80% of R&C after deductible for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 71).	70% after deductible for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 71).	70% of R&C after deductible for life-threatening injury or illness (See “Life-threatening Illness or Injury in the “Glossary” on page 71).

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Gender Reassignment Surgery (and related costs)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Preauthorization is required	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Preauthorization is required	70% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Preauthorization is required	50% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Preauthorization is required
Gynecology visits	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 80% after deductible	60% of R&C after deductible	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Hearing care	80% after deductible. Routine hearing screenings performed by a PCP (such as whispered voice, tuning fork), which do not utilize calibrated instrument are covered at 100% when provided as part of a preventive/wellness visit. Hearing exams utilizing calibrated instruments not covered. Covered hearing aids limited to $5,000 every 3 years per covered person (combined in-network/out-of-network).	60% of R&C after deductible Covered hearing aids limited to $5,000 every 3 years per covered person.(combined in-network/out-of-network).	80% after deductible. Routine hearing screenings performed by a PCP (such as whispered voice, tuning fork), which do not utilize calibrated instruments are covered at 100% when provided as part of a preventive/wellness visit. Hearing exams utilizing calibrated instruments not covered. Covered hearing aids limited to $5,000 every 3 years per covered person (combined in-network/out-of-network).	60% of R&C after deductible Covered hearing aids limited to $5,000 every 3 years per covered person (combined in-network/out-of-network).
Home health care	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients Preauthorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients Preauthorization is required	70% after deductible for up to 120 home health care aid visits per calendar year for homebound patients Preauthorization is required	50% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients Preauthorization is required
Hospice care	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	70% after deductible Preauthorization is required	50% of R&C after deductible Preauthorization is required
Immunizations (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Infertility Services	80% after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000* per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility. Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.	60% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000* per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility. Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.	70% after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000* per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility. Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.	50% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $20,000* per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis of infertility. Preauthorization is required *Prescription drugs related to infertility are covered under the prescription drug benefit and a separate lifetime maximum benefit cap of $20,000 applies for prescription drugs related to infertility.
Inpatient hospital services	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	70% after deductible Preauthorization is required	50% of R&C after deductible Preauthorization is required
Laboratory charges	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Magnetic resonance imaging – MRI	80% after deductible Preauthorization is required for MRIs	60% of R&C after deductible is required	70% after deductible Preauthorization is required for MRIs	50% of R&C after deductible is required
Mammograms, including 3D mammograms (Routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Mastectomy – reconstructive surgery	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Maternity hospital stay	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Mental health	***Inpatient and Residential Treatment*** 80% after deductible Subject to preauthorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment*** 60% of R&C after deductible Subject to preauthorization ***Outpatient:*** 60% of R&C after deductible	***Inpatient and Residential Treatment*** 70% after deductible Subject to preauthorization ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment*** 50% of R&C after deductible Subject to preauthorization ***Outpatient:*** 50% of R&C after deductible
Musculoskeletal surgery	100% after deductible if care is received at a IOQ as determined by the Claims Administrator 80% after deductible for Non-IOQ Preauthorization is required	60% of R&C after deductible Preauthorization is required	100% after deductible if care is received at a IOQ as determined by the Claims Administrator 70% after deductible for Non-IOQ Preauthorization is required	50% of R&C after deductible Preauthorization is required

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Obesity Surgery	80% after deductible Once per lifetime All services must be obtained from a recognized in-network IOQ Preauthorization is required	All services must be obtained from a recognized in-network IOQ	80% after deductible Once per lifetime All services must be obtained from a recognized in-network IOQ Preauthorization is required	All services must be obtained from a recognized in-network IOQ
Occupational therapy	80% after deductible. Medical Necessity Required.	60% of R&C after deductible. Medical Necessity Required.	70% after deductible. Medical Necessity Required.	50% of R&C after deductible. Medical Necessity Required.
Organ transplant	100% after deductible in IOQ as determined by the Claims Administrator 80% after deductible in Non-IOQ Preauthorization is required	60% of R&C after deductible Preauthorization is required	100% after deductible in IOQ as determined by the Claims Administrator 70% after deductible in Non-IOQ Preauthorization is required	50% of R&C after deductible Preauthorization is required
Outpatient physician services	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Physical exams for adults (routine)	Covered at 100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year	Covered at 100% (not subject to deductible) for one physical exam each calendar year	50% of R&C after deductible for one physical exam each calendar year
Physical exams for children (routine)	Covered at 100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits	Covered at 100% (not subject to deductible) Subject to Plan limits	50% of R&C after deductible Subject to Plan limits
Physical therapy	80% after deductible. Medical Necessity Required.	60% of R&C after deductible. Medical Necessity Required.	70% after deductible. Medical Necessity Required.	50% of R&C after deductible. Medical Necessity Required.

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Virtual Physical Therapy (Sword Health)	Prior to deductible: $29/month for unlimited sessions per month. After meeting deductible: subject to coinsurance on $29/month for unlimited sessions per month.	Not covered – all services must be provided by Sword Health	Prior to deductible: $29/month for unlimited sessions per month. After meeting deductible: subject to coinsurance on $29/month for unlimited sessions per month.	Not covered – all services must be provided by Sword Health
Pregnancy termination	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Prenatal visits	80% after deductible first visit only Routine Prenatal Care covered at 100%	60% of R&C after deductible	70% after deductible first visit only Routine Prenatal Care covered at 100%	50% of R&C after deductible
Prescription drugs (see "Prescription Drugs" on page 35)	There is a pharmacy network for 30-day and 90-day prescription drugs.	There is a pharmacy network for 30-day and 90-day prescription drugs.	There is a pharmacy network for 30-day and 90-day prescription drugs.	There is a pharmacy network for 30-day and 90-day prescription drugs.
Private Duty Nursing	80% after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network) Preauthorization is required	60% of R&C after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network) Preauthorization is required	70% after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network) Preauthorization is required	50% of R&C after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network) Preauthorization is required
Prostate specific antigen test – PSA (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Skilled nursing facility	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required.	60% of R&C after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required.	70% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required.	50% of R&C after deductible for 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required.
Speech therapy	80% after deductible. Medical Necessity Required.	60% of R&C after deductible. Medical Necessity Required.	70% after deductible. Medical Necessity Required.	50% of R&C after deductible. Medical Necessity Required.
Surgery	80% after deductible Preauthorization is required if in-patient	60% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	70% after deductible Preauthorization is required if in-patient	50% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures
Tubal ligation	Covered at 100%, deductible does not apply	60% of R&C after deductible	Covered at 100%, deductible does not apply	50% of R&C after deductible
Urgent Care	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Vasectomy	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Virtual Medicine	80% after deductible	Not covered	70% after deductible	Not covered
Vision care (routine eye care)	Not covered	Not covered	Not covered	Not covered

	$1,500 Deductible Plan		$3,000 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Vision Therapy/ Orthoptics	80% after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	60% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	70% after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	50% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)
X-rays	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

What's Not Covered

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The Claims Administrator may modify this list at their discretion, and you will be notified of any such change.

Alternative Treatments

- Acupressure
- Aroma therapy
- Hypnotism
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care.
- Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Car seats
  - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners
  - Dehumidifiers
  - Humidifiers
  - Devices and computers to assist communication and speech
  - Exercise equipment and treadmills.
  - Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).
  - Hot and cold compresses
  - Hot tubs
  - Jacuzzis
  - Medical alert systems
  - Motorized beds, non-Hospital beds, comfort beds and mattresses
  - Music devices
  - Personal computers
  - Pillows
  - Power-operated vehicles

- Radios
- Safety equipment
- Saunas
- Stair lifts and stair glides
- Strollers
- Treadmills
- Vehicle modifications such as van lifts
- Video player
- Whirlpools

Dental

- Dental care except when necessary because of accidental damage to an unrestored tooth. Such services must be performed by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Dental services for final treatment to repair the damage must be started within 12 months of the accident and completed in the calendar year or within the following calendar year.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- Dental implants, bone grafts, and other implant-related procedures
- Dental braces (orthodontics)
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia. The only exceptions to this are for any of the following:
  - Transplant preparation
  - Initiation of immunosuppressives
  - The direct treatment of acute traumatic injury, cancer or cleft palate
- Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly.
- Endodontics, periodontal surgery and restorative treatment

Drugs

- Over-the-counter drugs and treatments

Experimental or Investigational Services or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance use or health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the US Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopea Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming, cutting, or debriding (surgical removal of tissue)
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - Other services that are performed when there is not a localized illness, injury or symptom involving the foot
- Treatment of flat feet
- Treatment of subluxation (partial dislocation) of the foot
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages
  - Gauze and dressings
  - Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient
- Orthotic Devices (excluding foot orthotics) are described as: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. Orthotics (excluding foot orthotics) are covered by the Aetna plan when medically necessary
- Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment
- Tubings and masks except when used in association with Durable Medical Equipment
- Repair or replacement of Durable Medical Equipment or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items

Mental Health/Substance Use

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for mental health and substance use that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias
- Treatment provided in connection with or to comply with commitments, police detentions and other similar arrangements, unless authorized by the Plan's preauthorization review service

The Plan's preauthorization review service may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets criteria:

- Preventive counseling provided in connection with tobacco dependency in excess of 8 visits per 12 months

Nutrition

- Megavitamin and nutrition based therapy
- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs, health clubs and spa programs except when necessary in treating chronic disease states in which dietary adjustment has a therapeutic role and is prescribed by a physician and furnished by a provider as preventive care (e.g., a registered dietician, licensed nutritionist or other qualified licensed health provision) recognized under the plan.
- Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

Physical Appearance

- Cosmetic procedures. Examples include:
  - Pharmacological regimens (e.g., systematic course of drugs), nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
  - Skin abrasion procedures performed as a treatment for acne
  - Orthognathic surgery, for cosmetic reasons
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs are generally excluded except in cases of hair loss due a severe medical condition or treatment.
- Hair removal or replacement by any means
- Treatments for skin wrinkles or any treatment to improve the appearance of the skin
- Treatment for spider veins
- Skin abrasion procedures performed as a treatment for acne
- Treatments for hair loss
- Varicose vein treatment of the lower extremities, when it is considered cosmetic

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

- Health services and associated expenses for infertility treatments (except those described under Infertility Treatment)
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.) are not covered. (This is only covered when it's medically necessary.)
- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and / or storage of frozen embryos.

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services while on active military duty.

TMJ

- Surface electromyography
- Doppler analysis
- Vibration analysis
- Computerized mandibular scan or jaw tracking
- Craniosacral therapy
- Orthodontics
- Occlusal adjustment
- Dental restorations
- Any charges for services that are dental in nature.

Transplants

- Health services for organ and tissue transplants, except those described under Organ Transplants
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Any solid organ transplant (e.g. heart, lung, etc.; not blood, bone marrow, etc.) that is performed as a treatment for cancer
- Any multiple organ transplant not listed as a covered service.

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Except as described in the Travel and Lodging section, travel or transportation expenses to and from your home, even though prescribed by a physician.

Vision and Hearing

- Purchase cost of eye glasses, contact lenses
- Fitting charge for hearing aids, eye glasses or contact lenses
- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery.
- Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants)

Work-Related Accident and Illness

The Plan does not cover work-related accidents or illnesses. Work-related accidents and illnesses should be reported as soon as they occur to your Human Resources representative for consideration under the Worker's Compensation program.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Service
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Treatment for insomnia dementia and neurological disorders and other conditions without a known basis (e.g., Treatment for insomnia, nightmare or hypersomnolence without medical, mental health or other sleep disorder co-morbidity, unspecified sleep-wake or hypersomnolence disorder, unspecified neurocognitive disorder, factitious disorder)
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan
- In the event that a non-network provider waives the annual deductible for a particular health service, no benefits are provided for the health service for which the annual deductible are waived
- Charges in excess of eligible expense or in excess of any specified limitation
- Custodial care
- Domiciliary care (e.g., group living arrangements)
- Private duty nursing while INPATIENT
- Respite care
- Rest cures
- Treatment of benign gynecomastia (abnormal breast enlargement in males)

- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the reasonable and customary charge
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statues
- Any additional charges submitted after payment has been made and your account balance is zero
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Speech therapy to treat stuttering, stammering, or other articulation disorders.

Filing a Claim

How do I file a claim for medical benefits?

If you use an in-network provider, in almost all cases, you do not have to file a claim form. The provider will file a claim directly with the Claims Administrator. Once the claim is processed you will be billed for the appropriate coinsurance amount and/or deductible.

If you receive services from a provider who does not participate in the network, you need to file a claim form to receive benefits.

You can obtain a Medical Benefits Request Form from the Claims Administrator.

Read and follow the form’s instructions. Be sure to file a separate claim form for each member of your family. Make copies of all itemized bills and attach the originals to the claim form. You will also need to indicate whether you want the payment to go to the provider or to you.

Mail the completed claim form and all relevant documentation as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services.

You have 12 months following the date the expense was incurred to file a medical claim.

How long does it normally take to process a claim for medical benefits?

Most claims are normally processed within 14 business days after the claim is received by the Claims Administrator.

You can find out the status of your claims by visiting the Claims Administrator's website.

How do I file a prescription drug claim form?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable deductible or coinsurance. Rarely will you need to file a claim with the Prescription Drug Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Prescription Drug Benefits Manager.

Claim forms are available on the Pharmacy Drug Benefits Manager's website. Should you need to file a claim you are responsible for the contracted rate less coinsurance. You have 12 months from the date the expense was incurred to submit a claim.

How do I file a claim for hospital charges?

Hospitals will submit a claim from your hospital stay directly to the Claims Administrator. After receiving reimbursement from the Claims Administrator, the hospital will then bill you for any coinsurance or amount not eligible for reimbursement.

Be sure to review the hospital bill and to request an explanation of any charges that you question or do not understand. You should let the Claims Administrator know if you have a concern about the charges on your hospital bill.

You have up to 12 months following the date the expense was incurred to file a claim.

Can I be reimbursed for claims incurred outside the United States?

No, you cannot be reimbursed for services incurred outside the US unless they are considered emergency services. If you incur eligible emergency medical or prescription drug expenses while living or traveling outside of the US, your claim's processing will be expedited if the receipts are in English or if the person providing the services gives you a letter in English explaining the treatment. The Claims Administrator will convert the bill to US dollars using an exchange rate on the day the services were performed.

You have 12 months following the date the expense was incurred to file a claim.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits statement outlines how the amount of benefit, if any, was calculated. The statement also shows your year-to-date deductible and out-of-pocket expenses. If you are due reimbursement, a check will be mailed to you with an explanation of benefits statement, or to the provider if you assigned payment.

An Explanation of Benefits statement lets you verify that the claim was processed correctly. Always read your statement carefully, checking to make sure that you were billed only for:

- Services you received, on the day(s) you received them, only from the provider of care
- The exact type of services you received (e.g., if you participated in a group therapy session, make sure that you are not billed for individual treatment)
- The amount you were told the treatment would cost
- The type of medication you received (e.g., if you receive generic medication, check that you are not billed for brand name medication).

If your statement lists services you did not receive, please notify the Claims Administrator.

If you authorize that reimbursement be made directly to your provider, both you and the provider will receive an Explanation of Benefits statement, and the provider receives payment.

What happens if I am overpaid for a claim?

If the Plan overpays benefits to you (or a covered family member), you are required to refund any benefit you receive from the Plan that:

- Was for an expense that you (or a covered family member) did not pay or were not legally required to pay;
- Exceeded the benefit payable under the Plan; or
- Is not covered by the Plan.

If a benefit payment is made to you (or a covered family member), which exceeds the benefit amount, this Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or a covered family member.

Appealing a Claim

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

Glossary

Actively-At-Work

If you are eligible for coverage and enroll as a new hire, you are "Actively-At-Work" on the first day that you begin fulfilling your job responsibilities with the Company at a Company-approved location. If you are absent for any reason on your scheduled first day of work, your coverage will not begin on that date. For example, if you are scheduled to begin work on August 3rd, but are unable to begin work on that day (e.g., because of illness, jury duty, bereavement or otherwise), your coverage will not begin on August 3rd. Thereafter, if you report for your first day of work on August 4th, your coverage will be effective on August 4th.

After-tax (Post-tax) Contributions

Contributions taken from your paycheck after taxes are withheld.

Before-tax (Pre-tax) Contributions

Contributions taken from your paycheck generally before Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state, and other income taxes are withheld.

Claims Administrator/Prescription Drug Benefits Manager

Vendor that administers the Plan and processes claims; the vendor's decisions are final and binding.

Coinsurance

The percentage of expenses the plan pays after you meet your deductible. For purposes of the charts in this document, the percentages represent the portion of the costs that the Plan pays for covered services. So, for example, if the chart indicates 80%, the portion you will be responsible for is 20%.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Coordination of Benefits

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from this plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

COVERED SERVICE(S)

Medically necessary health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered health services must be provided:

- When the Plan is in effect,
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description, and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or group studies.

The Claims Administrator determines only the extent to which a service or goods or supplies is covered under the plan and not whether the service or goods or supplies should be rendered. The coverage determination is made using the descriptions of covered charges included in this section and the Claims Administrator's own internal guidelines. The decision to accept a service or obtain a goods or supplies is yours.

DEDUCTIBLE

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

DISABILITY

A physical or mental impairment that substantially limits one or more of an individual's major life activities.

ELIGIBLE FAMILY MEMBERS

To cover an eligible family member, you will be required to certify in the Mercer Marketplace Benefits Enrollment Website that your eligible family member meets the eligibility criteria as defined below.

Spouse/Domestic Partner means:

Spouse / Domestic Partner

- You have already received a marriage license from a US state or local authority, or registered your domestic partnership with a US state or local authority.

Spouse Only

- Although not registered with a US state or local authority, your relationship constitutes a marriage under US state or local law (e.g. common law marriage or a marriage outside the US that is honored under US state or local law).

Domestic Partner Only

- Although not registered with a US state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - Be at least 18 years old
  - Not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - Currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - Currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - Have agreed to share responsibility for each other's common welfare and basic financial obligations
  - Not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh McLennan reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

Child/Dependent Child means:

- Your biological child
- A child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- The child of a domestic partner
- Your stepchild
- Your legally adopted child or a child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

Eligible Retiree

An employee is eligible for coverage under this plan if he/she is a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other MMA and any of its subsidiaries) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree (under or over age 65) enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or is deemed to be eligible for Medicare, the person who is age 65 or is eligible for Medicare is no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

Evidence of Insurability (EOI)

Evidence of Insurability (EOI) is proof of good health and is generally required if you do not enroll for coverage when you first become eligible. If the coverage level you are requesting requires such evidence or if you are increasing coverage. Establishing EOI may require a physical examination at the employee's expense. The EOI must be provided to and approved by the insurer/vendor before coverage can go into effect.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to the Global Benefits Department, located at 1166 Avenue of the Americas, 31st Floor, New York, NY 10036.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans including concerning the use and disclosure of individual health information.

Hospice

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

In-network Providers

Preferred health care providers who have agreed to charge reduced fees to members.

Inpatient

Being treated and admitted at a covered facility for an overnight stay either by a physician or from the emergency room.

Life Threatening Illness or Injury– Emergency Room Coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies include:

- Heart attack, suspected heart attack or stroke
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath
- High fever (103 degrees or higher), especially in infants
- Uncontrolled or severe bleeding
- Loss of consciousness
- Severe abdominal pain
- Persistent vomiting
- Severe allergic reactions.

The Plan covers emergency services necessary to screen and stabilize a member when:

- A primary care physician or specialist physician directs the member to the emergency room
- A plan representative (employee or contractor) directs the member to the emergency room
- The member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed.

Marsh McLennan Medical Plans and Medicare Prescription Drug Coverage for Disabled Employees

Marsh McLennan newsletter that provides an overview of how Medicare Part D could affect your Marsh McLennan Companies prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

MEDICALLY NECESSARY

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance disorders that, in reasonable judgment of the Plan's preauthorization review service, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions
- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome
- Typically, do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
- Not consistent with the Plan's preauthorization review service's guidelines or best practices as modified from time to time.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html or by calling the number on your ID card.

MEDICARE

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

NOTICE OF CREDITABLE COVERAGE

The Medicare Modernization Act requires all group health plan sponsors that offer prescription drug coverage to provide notices to covered employees, retirees, and their dependents who are eligible for Medicare's new prescription drug benefit (Part D).

OUT-OF-NETWORK PROVIDERS

Non-preferred health care providers who do not charge reduced fees to members.

OUT-OF-POCKET EXPENSES

Subject to the following, the maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the reasonable and customary charge.

OUTPATIENT

Treatment/care received at a clinic, emergency room or health facility without being admitted as an overnight patient.

PREDETERMINATION OF BENEFITS

This feature helps you estimate how much the Plan may pay (subject to your deductible and Plan maximum at the time the estimate is provided) before you begin treatment. It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

A review service that helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

Preauthorization/Precertification/Utilization Review

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services.

The following website can be used to view a list of services that require precertification. This https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html

PRE-EXISTING CONDITION

A health problem you had and received treatment for before your current benefit elections took effect.

Prescription Drugs

- Formulary/Brand Name (Preferred) Prescription Drugs. A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- Generic Prescription Drugs. Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- Non-Formulary (Non-Preferred) Prescription Drugs. Prescription drugs that do not appear on the formulary list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

Preventive/Wellness Care

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

Qualified Family Status Change (Status Change, Qualified Change in Family Status, Life or Family Change)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

Qualifying Event

A “qualifying event” under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child’s loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Reasonable & Customary (R&C) Charges/Fees

Charges/fees that do not exceed the prevailing charges for comparable services in your provider’s area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. The plan’s reasonable and customary guidelines for professional services typically include up to the 85th percentile value reported in a database prepared by FAIR Health and facilities typically include the full eligible charge.

The plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Claims Administrator regularly reviews the reasonable and customary charge schedule. To confirm whether your provider's charges are within the reasonable and customary limit, obtain a Predetermination of Benefits.

Note that the reasonable and customary charge does not apply to specific services per the Consolidated Appropriations Act of 2021 (CAA); cost share is based on the median contracted rate and the plan covers the full amount.

- Services provided by certain out-of-network providers at an in-network facility
- Out-of-Network Air Ambulance Services
- Out-of-Network Emergency services

RESIDENTIAL TREATMENT FACILITY

An institution specifically licensed as a residential treatment facility by applicable laws to provide for mental health or substance related disorder residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:

For residential treatment programs treating mental health disorders:

- A behavioral health provider must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program

For substance related residential treatment programs:

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

For detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting

Third Party Administrator

Each self-insured medical plan has a third party administrator (TPA) that sets the provider network for that medical plan.

The TPA also provides administrative services for that medical plan including record-keeping, enrollment and claims and appeals adjudication, and serves as the sole “Claims Administrator” for that plan. The TPA’s decisions as claims administrator are final and binding.

Waiting Period/Elimination Period

The amount of time you must wait before being able to participate in a plan.