# MEDICAL COVERAGE

## Summary Plan Description

**Self-Insured**

The IQVIA Medical Plan administered by Aetna is not an insured plan. The benefits under the plan are self-insured by IQVIA which is responsible for their payment.

The IQVIA Medical Plan combines traditional medical, preventive, surgical, hospitalization and major medical coverage into one plan. Under the plan, you retain all of the valuable benefits available under managed care programs, (e.g., pre-certification of all inpatient hospital admissions and certain outpatient procedures). And, you maintain the flexibility and convenience of self-management, (e.g., choice of doctors, no primary care physician and no referrals). There are four medical plan options administered by Aetna—the $400 Deductible PPO Plan, $900 Deductible PPO Plan, $1,850 Deductible Plan with Health Savings Account (HSA) and $2,850 Deductible Plan with Health Savings Account (HSA). Employees in California and Georgia can choose between Kaiser and Aetna.

If you are eligible to participate in the IQVIA Medical Plan, you may choose the plan option that best meets your individual needs. The quality, covered services and provider networks are the same under all four plans, but the amount you pay for care depends on which plan you choose.

**For More Information**

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

## IN THIS SECTION ..... SEE PAGE

# AT A GLANCE

**Questions?**

If you have questions about your medical benefits, call Aetna at 800-726-4366 or Kaiser at 800-464-4000, or log on to their websites at www.aetna.com or https://healthy.kaiserpermanente.org.

The Aetna Medical Plan options are network-based, meaning the benefits will be richer if you use a preferred network physician or hospital. However, you are welcome to see out-of-network providers if you choose, and benefits will be paid at the out-of-network rate.

If you choose Kaiser, coverage is in-network only. There is no coverage out of the network (except emergency care).

Here is a quick look at what each of the plan options cover.

| Medical Options | $400 Deductible PPO Plan | | $900 Deductible PPO Plan | | $1,850 Deductible Plan with HSA | | $2,850 Deductible Plan with HSA | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible** | | | | | | | | |
| ■ Individual | ■ $400 | ■ $2,500 | ■ $900 | ■ $3,000 | ■ $1,850 | ■ $3,700 | ■ $2,850 | ■ $5,700 |
| ■ Family | ■ $800 | ■ $5,000 | ■ $1,800 | ■ $6,000 | ■ $3,700 | ■ $7,400 | ■ $5,700 | ■ $11,400 |
| **Coinsurance for most covered services** | 80% | 60% | 80% | 60% | 80% | 60% | 70% | 50% |
| **Annual Medical Out-of-Pocket Maximum** | | | | | | | | |
| ■ Individual | ■ $2,200 | ■ $4,400 | ■ $3,000 | ■ $6,000 | ■ $3,500 | ■ $7,000 | ■ $5,500 | ■ $11,000 |
| ■ Family | ■ $4,400 | ■ $8,800 | ■ $6,000 | ■ $12,000 | ■ $6,500 | ■ $13,000 | ■ $11,000 | ■ $22,000 |
| **Lifetime Maximum** | | | | | | | | |
| **Preventive Care** | 100% | 60%, after deductible | 100% | 60%, after deductible | 100% | 60%, after deductible | 100% | 50%, after deductible |
| **Physician Office Visits** | Primary Care Physician: $20 copay<br>Specialists: $40 copay<br>Deductible doesn't apply | 60%, after deductible | Primary Care Physician: $40 copay<br>Specialists: $80 copay<br>Deductible doesn't apply | 60%, after deductible | 80%, after deductible | 40%, after deductible | 70%, after deductible | 50%, after deductible |

| Medical Options | $400 Deductible PPO Plan | | $900 Deductible PPO Plan | | $1,850 Deductible Plan with HSA | | $2,850 Deductible Plan with HSA | |
|---|---|---|---|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Telehealth* (Teladoc)** (online video or phone appointments for treatment of non-emergency medical issues) | $20 copay; deductible doesn't apply | | $20 copay; deductible doesn't apply | | $49 copay until deductible is met; then 80% coinsurance | | $49 copay until deductible is met; then 40% coinsurance | |
| **Inpatient Hospital Services** | 80% after deductible | 60%, after deductible | 80% after deductible | 60% after deductible | 80% after deductible | 60% after deductible | 70%, after deductible | 50%, after deductible |

*Available with the Aetna plans only.

# ANSWERS TO FREQUENTLY ASKED QUESTIONS

### What does the annual medical out-of-pocket maximum include?

The annual out-of-pocket maximum includes the calendar year deductible, office visit copays and coinsurance. It does not include any costs not covered by the plan—like costs above Maximum Reimbursable Charges (MRC).

### How does the family deductible and out-of-pocket maximum work in the $1,850 and $2,850 Deductible Plans with HSA?

In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family deductible before the plan pays benefits for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the deductible.

The same rule applies to the out-of-pocket maximum before the plan pays 100% of covered expenses for any family member.

If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual only needs to meet the individual deductible before the plan pays benefits for that individual member. The same rule applies to the out-of-pocket maximum before the plan pays 100% of covered expenses for that individual member.

### What happens if my doctor drops out of the network?

You will need to choose another doctor from the Aetna provider directory to receive network benefits. Keep in mind that you can go to any doctor in the network, and you do not have to choose a primary care physician. You can continue to see a doctor who has dropped out of the network, but you will receive lower benefits for out-of-network care. If you choose Kaiser, you will need to find another doctor from the Kaiser network.

### When do I receive my health plan ID card after I enroll as a new hire?

You should receive ID cards (depending on your elections) within 2-3 weeks to your home address:

- Aetna: Each family will be issued two (2) ID cards. If you wish to print additional cards, please sign into your Aetna account at www.aetna.com, or download the Aetna app to your mobile device, where you can also view an electronic ID card.
- Kaiser: Each covered member will receive an ID card, which will serve as a combined medical and prescription card. If you wish to print additional cards, you can do so at https://healthy.kaiserpermanente.org.

### How can I view my claims status?

You can view the status of your claims:

- At www.aetna.com. Log in and click, "Manage Claims" at the top of the Welcome page.
- At https://healthy.kaiserpermanente.org. Log in and click "Coverage and Costs."

If you're not registered to use the Aetna or Kaiser websites, use these instructions below:

- Aetna: Go to www.aetna.com and click "Log In/Register." You will need to enter your member ID, which is located on your ID card, first and last name, date of birth, zip code and an email address. Then, click "Continue" and follow the prompts to set up your account.
- Kaiser: Go to https://healthy.kaiserpermanente.org and click "Register." Then click "I have a Kaiser Permanente plan and want to use online services." You will need to enter your first and last name, date of birth, preferred language, region and medical record number (MRN) from your ID card. Note: Northern CA employees do not need to include the "11" prefix in the MRN.

# HOW THE MEDICAL PLAN WORKS

There are four levels of medical coverage:

- **$400 Deductible PPO Plan:** Offers the lowest deductibles and out-of-pocket costs when you need medical services. However, the monthly contributions for coverage are the highest.
- **$900 Deductible PPO Plan:** Higher deductibles and out-of-pocket costs than the $400 Deductible PPO Plan, but lower monthly contributions.
- **$1,850 Deductible Plan with HSA**: Offers a higher deductible and out-of-pocket costs with the lower monthly contributions for coverage than the $900 Deductible PPO Plan.
- **$2,850 Deductible Plan with HSA**: Offers the highest deductible and out-of-pocket costs with the lowest monthly contributions for coverage.

With all four options:

- Each time you receive care with Aetna, you can choose to receive care from in-network or out-of-network providers. If you choose Kaiser, coverage is in-network only (except for emergency care).
- Aetna offers a network of providers who have agreed to charge lower, fixed fees for services. You save money by using in-network providers.
- With Aetna, out-of-network care is generally subject to a higher annual deductible, and expenses are covered at a lower percentage than in-network services.
- When you enroll in any Medical Plan option, you are automatically enrolled in the Prescription Drug Program administered by Express Scripts (Aetna) or Kaiser.

## IN-NETWORK BENEFITS

Aetna has selected a group of health care professionals and facilities for the Choice POS II network. All providers in the network must meet certain quality criteria established by Aetna. The network monitors the quality of service patients receive through regular practice reviews, site visits, chart reviews and numerous other measures.

When you receive in-network care, the following benefit features apply:

- You are covered at 100% for eligible preventive care.
- Physician office visits are subject to a copay in the $400 Deductible PPO Plan and $900 Deductible PPO Plan; the deductible doesn't apply. In the $1,850 Deductible Plan with HSA and $2,850 Deductible Plan with HSA you pay coinsurance after the deductible is met.
- Pre-certification for inpatient hospitalizations and certain outpatient services are managed by the doctors for you.
- The doctors have agreed to accept negotiated fees that are generally lower than what you would pay out-of-network; as a result, Maximum Reimbursable Charges (MRC) do not apply.

Kaiser's exclusive network of providers allows members to access all services under one roof, including primary and specialty care, lab, X-ray and pharmacy. All providers in the network must meet certain quality criteria established by Kaiser. The network monitors the quality of service patients receive through regular practice reviews, site visits, chart reviews and numerous other measures.

When you receive in-network care, the following benefit features apply:

- You are covered at 100% for eligible preventive care.
- Physician office visits are subject to a copay in the $400 Deductible PPO Plan and $900 Deductible PPO Plan; the deductible doesn't apply. In the $1,850 Deductible Plan with HSA and $2,850 Deductible Plan with HSA you pay coinsurance after the deductible is met.

- Pre-certification for inpatient hospitalizations and certain outpatient services are managed by the network doctors for you. If you are using out-of-network providers, you are responsible for the pre-certification and you will incur a financial penalty if you do not obtain the pre-certification.

To find a doctor in the network:

- Aetna: Go to www.aetna.com/docfind. (If you're not registered to use www.aetna.com, click "Log In/Register." You will need to enter your member ID, which is located on your ID card, first and last name, date of birth, zip code and an email address. Then, click "Continue" and follow the prompts to set up your account.) Once you're logged in, click "Find Care," on the welcome page.
- Kaiser: Go to https://healthy.kaiserpermanente.org. (If you're not registered to use https://healthy.kaiserpermanente.org, click "Register." Then click "I have a Kaiser Permanente plan and want to use online services." You will need to enter your first and last name, date of birth, preferred language, region and medical record number (MRN) from your ID card. Note: Northern CA employees do not need to include the "11" prefix in the MRN.) Once you're logged in, click "Coverage and Costs."

If you need any assistance locating a provider in the network, call Aetna at 800-726-4366 or Kaiser at 800-464-4000.

## OUT-OF-NETWORK BENEFITS

In the Aetna plans, you can choose to visit an out-of-network physician, hospital or other provider at any time. If you receive covered services on an out-of-network basis:

- Services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, based on Maximum Reimbursable Charge (MRC) limits for covered services. You are responsible for any amounts above the MRC limits.
- For out-of-network care, you are responsible for filing any required claim forms, obtaining authorizations for hospital admissions and obtaining any required pre-certification for services.

### Maximum Reimbursable Charges (MRC)

For most services, Maximum Reimbursable Charge (MRC) limits are based on a fee schedule (developed using a Medicare-based methodology). For some services, MRC limits are based on what providers with similar professional backgrounds, education and experience charge for a specific service within a given area. The plans cover costs up to MRC limits and you are responsible for paying any portion of the bill over the limits. Charges above MRC amounts will not apply toward your deductible, coinsurance or annual out-of-pocket maximum.

## IF YOU LIVE OUTSIDE THE NETWORK AREA

In the Aetna plans, if you are unable to locate an in-network provider in your area who can provide you with a service or supply that is covered under the Medical Plan, call the number on the back of your ID card to request authorization for out-of-network provider coverage. If you get authorization for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level. You will still be responsible for paying any portion of the bill over the in-network benefit level.

In the Kaiser plans, if you move outside of your network area, you can continue to use the Kaiser providers or switch to an Aetna plan. If you move out of California or Georgia, you would have the option to elect an Aetna plan.

# PAYING FOR YOUR CARE

In-network preventive care is covered at 100%. For all other services, you pay a copay and/or you must meet the annual deductible before you and IQVIA begin to share the cost of services.

## DEDUCTIBLE

**Deductible**

The deductible is the amount you pay each year for eligible medical expenses before the plan begins to pay for certain benefits.

The deductible is the amount of covered charges you pay each year before the plan begins paying benefits. Exceptions include in-network preventive care and in-network physician office visits ($400 Deductible PPO Plan and $900 Deductible PPO Plan).

Only covered services count toward the deductible. This includes Maximum Reimbursable Charges (MRC) for medically necessary services out-of-network. Amounts above MRC limits are not covered services and do not count toward your deductible.

The annual deductible for each option is shown below:

| Coverage Type | $400 Deductible PPO Plan | | $900 Deductible PPO Plan | | $1,850 Deductible Plan with HSA | | $2,850 Deductible Plan with HSA | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Individual | $400 | $2,500 | $900 | $3,000 | $1,850 | $3,700 | $2,850 | $5,700 |
| Family | $800 | $5,000 | $1,800 | $6,000 | $3,700 | $7,400 | $5,700 | $11,400 |

- In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family deductible before the plan pays benefits for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the deductible.
- If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual only needs to meet the individual deductible before the plan pays benefits for that individual member.

## COINSURANCE

For most services, after you meet the deductible, you and IQVIA each pay for a percentage of the cost. The percentages are based on if you choose in- or out-of-network care.

## COPAY

For certain services, like physician office visits (e.g., in the $400 Deductible PPO Plan and $900 Deductible PPO Plan), you pay a copay each time you receive care. In some instances, like emergency room care under the $400 Deductible PPO Plan, you pay a copay in addition to the coinsurance.

## ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM

Your annual medical out-of-pocket maximum is the most you must pay in a calendar year (including your annual deductible, office visit copays and coinsurance) toward covered eligible expenses.

Prescription copays under the $1,850 and $2,850 Deductible Plans with HSA also apply toward your medical deductible and out-of-pocket maximum. If you enroll in the $400 or $900 Deductible PPO Plan, prescription drug costs do not count toward the medical plan deductible; however, they do accumulate toward the out-of-pocket maximum.

In the Aetna plans, if you use an out-of-network provider, only Maximum Reimbursable Charges (MRC) for medically necessary services will count toward the annual out-of-pocket maximum. Amounts above MRC limits are not covered expenses and do not count toward your annual out-of-pocket maximum. The out-of-pocket maximum for each option is shown below:

| Coverage Type | $400 Deductible PPO Plan | | $900 Deductible PPO Plan | | $1,850 Deductible Plan with HSA | | $2,850 Deductible Plan with HSA | |
|---|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| ■ Individual | ■ $2,200 | ■ $4,400 | ■ $3,000 | ■ $6,000 | ■ $3,500 | ■ $7,000 | ■ $5,500 | ■ $11,000 |
| ■ Family | ■ $4,400 | ■ $8,800 | ■ $6,000 | ■ $12,000 | ■ $6,500 | ■ $13,000 | ■ $11,000 | ■ $22,000 |

- In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family out-of-pocket maximum before the plan pays 100% of covered expenses for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the out-of-pocket maximum.
- If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual needs to meet the out-of-pocket maximum before the plan pays 100% of covered expenses for that individual family member.

### A Quick Note about Deductibles and Out-of-Pocket Maximums

Deductibles and out-of-pocket maximums for in-network and out-of-network services are combined, which means that covered expenses cross accumulate between in and out-of-network deductibles and maximums. All other plan maximums and service-specific maximums also cross accumulate between in- and out-of-network, unless otherwise noted.

## MAXIMUM LIFETIME BENEFIT

The maximum lifetime benefit limit for in-network or out-of-network care for each covered individual is unlimited for covered expenses for the length of the time the individual is covered by the IQVIA Medical Plan. Some services and treatments have specific lifetime and/or calendar year limits. See "Benefits Covered by the Medical Plan" beginning on page 45 for details on special limits for specific covered services.

# OTHER PLAN FEATURES

This section describes features of the Medical Plan, including in- and out-of-network pre-certification, what to do if you need emergency care, case management, wellness tools and resources, benefits for hospital stays for mothers and newborns, and coverage for surgery following a mastectomy.

## PRE-CERTIFICATION

### Hospital Notification

To contact Aetna or Kaiser regarding a hospital stay, call the telephone number listed on your ID card.

### In-Network

Certain in-network services, such as hospital admissions and select outpatient services require pre-certification. You must obtain pre-certification from Aetna or Kaiser before you receive care for these services. Your network provider will obtain the necessary pre-certifications for you. If you are using out-of-network providers, you are responsible for the pre-certification, and you will incur a financial penalty if you do not obtain the pre-certification.

You may call Aetna or Kaiser for a detailed list of services. The list may change periodically.

Your network provider will also contact Aetna or Kaiser if a maternity stay will exceed 48 hours for the mother and newborn child following a vaginal delivery, or 96 hours for the mother and newborn child following a cesarean section delivery.

### Out-of-Network

Certain out-of-network services, such as hospital admissions and select outpatient services require pre-certification. To have your treatment pre-certified, you must call Aetna or Kaiser prior to receiving treatment. If you don't, your benefits may be reduced or denied.

If you have to be admitted to a hospital due to an emergency, you must call Aetna or Kaiser before you're admitted or as soon as reasonably possible.

## Services Requiring Pre-Certification

### Inpatient Settings

- All inpatient admissions and non-obstetric observations stays such as:
  - Acute hospitals
  - Hospice care
  - Long-term care facilities
  - Rehabilitation facilities
  - Skilled nursing facilities
  - Transfers between inpatient facilities
- Cochlear device and/or implantation.
- Cosmetic procedures.
- Experimental and investigational procedures.
- Gender reassignment surgery.
- Interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections)
- Major joint surgeries (hip, knee, shoulder)
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section).
- Musculoskeletal services, including major joint surgeries (hip, knee, shoulder) and interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections).
- Observation stays more than 24 hours.
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids.

### Outpatient Settings

- Behavioral health services requiring precertification/authorization including:
  - Applied behavior analysis (ABA)
  - Inpatient admissions
  - Intensive outpatient programs (IOPs)
  - Neuropsychological testing
  - Outpatient detoxification
  - Partial hospitalization programs (PHPs)
  - Psychological testing
  - Residential treatment center (RTC) admissions
  - Transcranial magnetic stimulation (TMS)
- Certain imaging services.
- Certain outpatient surgical procedures.
- Certain prescription and injectable drugs (specific listing of codes).
- Chemotherapy for cancer diagnosis.
- Chiropractic care.
- Cosmetic or reconstructive procedures.
- Diagnostic cardiology.
- Dialysis (when request is initiated by a participating provider, and dialysis to be performed at a non-participating facility).
- Durable medical equipment (specific listing of codes).
- External prosthetic appliances, (specific listing of codes).
- Genetic testing.
- High-tech radiology (MRI, CAT scans, PET scans).
- Home health care/home infusion therapy.
- Hyperbaric oxygen therapy.
- Infertility program.
- Infertility treatment.
- Mental health or substance abuse services.
- Musculoskeletal services, including major joint surgeries (hip, knee, shoulder) and interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections).
- National Medical Excellence Program®.
- Occupational therapy.
- Pain management.
- Physical therapy.
- Private duty nursing.
- Radiation therapy.
- Requests for services provided by a non-participating provider to be covered at in-network level.
- Sleep studies.
- Speech therapy.
- Ventricular assist devices.
- Video electroencephalograph (EEG).

### Additional Services

- Transportation by fixed-wing aircraft (plane).

## IF YOU NEED EMERGENCY CARE

If you have a medical emergency, you should call 911 or go to the nearest physician, hospital emergency room or other urgent care facility. Your emergency care will be covered based on the deductible and coinsurance provisions of your option.

## CASE MANAGEMENT

Case management is a service provided through a review organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that you receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for case management arise, a case management professional will work closely with you and your family and your physician to determine appropriate treatment options which will best meet your needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for your family in times of medical crisis.

Case managers are registered nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you (or your dependent). In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, your physician remains responsible for the actual medical care.

You (or your dependent) or your doctor can request case management services by calling the number on your ID card. In addition, you may be referred directly through Aetna or Kaiser.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

## WELLNESS TOOLS AND RESOURCES

### Aetna Navigator®

Register for Aetna Navigator® at www.aetna.com, Aetna's secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

### Aetna Navigator® Estimate the Cost of Care

Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna's secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

### Kaiser Permanente Online Resources

Register to use https://healthy.kaiserpermanente.org. On the site, you can access:

- A directory of plan facilities and plan physicians.
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments.
- Health education resources.
- Appointments and advice phone numbers.

You can also access tools and resources using the KP app on your smartphone or other mobile device.

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with the Newborns' and Mothers' Health Protection Act, group medical plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. Further, the plan cannot require that any medical provider obtain authorization from the plan or any insurance issuer for prescribing a length of stay not in excess of the above periods.

## WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Solely to the extent required under the Women's Health and Cancer Rights Act (WHCRA), the Medical Plan will provide certain benefits in connection with a mastectomy. The Medical Plan will include coverage for reconstructive surgery following a mastectomy.

If you or your eligible dependent(s) (including your spouse or domestic partner) are receiving benefits under the Medical Plan in connection with a mastectomy and elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and you or your eligible dependent(s) (including your spouse or domestic partner) for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. See the *Participating in the Health Care Plans* section for a definition of eligible dependents.

Reconstructive benefits are subject to annual plan deductibles and coinsurance provisions like other medical and surgical benefits covered under the Medical Plan.

# BENEFITS COVERED BY THE MEDICAL PLAN

All four medical options cover a variety of services, as long as the services are medically necessary. The level at which benefits are paid depends on which plan option you choose and whether you receive your care in-network or out-of-network. The following charts (one for each option) show the major provisions of each medical option. If you choose Kaiser, coverage is in-network only. There is no coverage out of the network (except emergency care). Differences in the plan's coverage for Kaiser are noted below.

To see details of these services, see "Covered Service Descriptions" beginning on page 58.

## $400 DEDUCTIBLE PPO PLAN

| | In-Network | Out-of-Network* |
|---|---|---|
| **Annual Deductible** | | |
| ■ Individual | ■ $400 | ■ $2,500 |
| ■ Family | ■ $800 | ■ $5,000 |
| **Coinsurance for most covered services** | 80%, after deductible | 60%, after deductible |
| **Annual Out-of-Pocket Maximum**** | | |
| ■ Individual | ■ $2,200 | ■ $4,400 |
| ■ Family | ■ $4,400 | ■ $8,800 |
| **Lifetime Maximum** | None | |
| **Preventive Care** | | |
| Routine care and office visits (includes X-ray and lab work when billed as preventive care) | 100% | 60%, after deductible |
| Immunizations:<br>(including travel immunizations and flu shots) | | |
| ■ Children through age 2 | 100% | 60%, after deductible |
| ■ Children age 3 and over and adults | 100% | 60%, after deductible |
| Mammograms*** | 100% | 60%, after deductible |
| Pap smears | 100% | 60%, after deductible |
| Other routine cancer screenings | 100% | 60%, after deductible |
| Skin cancer screenings when provider bills as preventive | 100% | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| Obesity or health diet counseling | 100% | 60%, after deductible |
| Screening and counseling services for misuse of alcohol or drugs | 100% | 60%, after deductible |
| Screening and counseling services to stop using tobacco products | 100% | 60%, after deductible |
| Sexually transmitted infection counseling | 100% | 60%, after deductible |
| **Physician Services** | | |
| Office visits<br>■ Primary care physician (PCP)<br>■ Specialty care physician<br>(Includes X-ray and lab work when performed and billed by the physician's office)<br>Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type | ■ PCP: $20 copay; deductible doesn't apply<br>■ Specialists: $40 copay; deductible doesn't apply | 60%, after deductible |
| Telemedicine (Teladoc) – Available with the Aetna plans only | $20 copay; deductible doesn't apply | |
| Surgery (physician's office) | 80%, after deductible | 60%, after deductible |
| Allergy injections/antigens/serum<br>Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance. | Aetna: 80%, after deductible; no copay<br>Kaiser: $15 copay | 60%, after deductible |
| Allergy testing and treatment (dispensed by physician's office)<br>Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit. | Aetna: 100% after applicable PCP or specialist copay; deductible doesn't apply<br>Kaiser: Applicable specialist copay applies | 60%, after deductible |
| **Hospital Services** | | |
| Inpatient hospital care<br>(semi-private room) | 80%, after deductible | 60%, after deductible |
| Inpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Inpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Outpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Outpatient facility services<br>Office/ambulatory surgery center PCP and specialist copay will apply based on provider status | 80%, after deductible | 60%, after deductible |
| Outpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility) | 80%, after deductible | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| **Maternity Care (Employee and dependent daughters)** | | |
| Physician's office (initial visit) | Aetna: $40 copay; deductible doesn't apply<br>Kaiser: 100% | 60%, after deductible |
| Physician's office (visits) | 100% | 60%, after deductible |
| Physician services (pre- and post-natal visits, delivery) | 80%, after deductible | 60%, after deductible |
| **Mental Health and Substance Abuse** | | |
| Inpatient services (facility, professional and other inpatient services) | 80%, after deductible | 60%, after deductible |
| Outpatient (individual or group therapy office visit) | $20 copay; deductible doesn't apply | 60%, after deductible |
| Outpatient services (facility, professional and other outpatient services) | 80% after deductible | 60% after deductible |
| **Emergency Services** | | |
| Ambulance | 80% after deductible | 80% after deductible |
| Emergency room<br>(waived if admitted) | Aetna: $150 per visit copay, then 80% after deductible<br>Kaiser: 80% after deductible | Aetna: $150 per visit copay, then 80% after deductible<br>Kaiser: 80% after deductible |
| Urgent care | Aetna: $50 copay; deductible doesn't apply<br>Kaiser: $20 copay; deductible doesn't apply | Aetna: 60%, after deductible<br>Kaiser: $20 copay; deductible doesn't apply |
| **Other Services** | | |
| Abortion/Voluntary Sterilization (dependents covered) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Acupuncture<br>(Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year) | ■ Office visit: $40 copay; deductible doesn't apply<br>■ Other covered services: 80%, after deductible | 60%, after deductible |
| Autism and ABA Therapy | $20 copay; deductible doesn't apply | 60%, after deductible |
| Bariatric surgery<br>(One per lifetime; no dollar limit) | 80%, after deductible | 60%, after deductible |
| Chiropractic care<br>(60 visits per calendar year) | $40 copay; deductible doesn't apply | 60%, after deductible |
| Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances) | 80%, after deductible; subject to office visit copays | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| Diagnostic X-ray & lab | Aetna: 80%, after deductible<br>Kaiser: $15 copay; deductible doesn't apply | 60%, after deductible |
| Durable medical equipment | Aetna: 80%, after deductible<br>Kaiser: 80%; deductible doesn't apply | 60%, after deductible |
| Genetic testing | 80%, after deductible | 60%, after deductible |
| Hearing aids (testing and exam) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Hearing aids (hardware - $1,000 per ear per calendar year) | 80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit) | 60%, after deductible |
| Home health care<br>(120 visits per calendar year) | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Hospice services | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Skilled nursing care (inpatient—120 days per calendar year) | 80%, after deductible | 60%, after deductible |
| Private duty nursing (outpatient—60 visits per calendar year) | 80%, after deductible | 60%, after deductible |
| Organ transplants:<br>■ Centers of Excellence<br>■ Non Centers of Excellence | <br>■ 80%, after deductible<br>■ 60%, after deductible | <br>■ N/A<br>■ 60%, after deductible |
| Prosthetic devices | 80%, after deductible | 60%, after deductible |
| Outpatient rehabilitative therapy | Aetna: $40 copay; deductible doesn't apply<br>Kaiser: $20 copay; deductible doesn't apply | 60% after deductible |
| Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis) | $40 copay in the physician's office; deductible and coinsurance applies in other places of service | 60% after deductible |

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

## $900 DEDUCTIBLE PPO PLAN

| | In-Network | Out-of-Network* |
|---|---|---|
| **Annual Deductible** | | |
| ■ Individual | ■ $900 | ■ $3,000 |
| ■ Family | ■ $1,800 | ■ $6,000 |
| **Coinsurance for most covered services** | 80%, after deductible | 60%, after deductible |
| **Annual Out-of-Pocket Maximum**** | | |
| ■ Individual | ■ $3,000 | ■ $6,000 |
| ■ Family | ■ $6,000 | ■ $12,000 |

| | In-Network | Out-of-Network* |
|---|---|---|
| **Lifetime Maximum** | None | |
| **Preventive Care** | | |
| Routine care and office visits (includes X-ray and lab work when billed as preventive care) | 100% | 60%, after deductible |
| Immunizations:<br>(including travel immunizations and flu shots) | | |
| ■ Children through age 2 | 100% | 60%, after deductible |
| ■ Children age 3 and over and adults | 100% | 60%, after deductible |
| Mammograms*** | 100% | 60%, after deductible |
| Pap smears | 100% | 60%, after deductible |
| Other routine cancer screenings | 100% | 60%, after deductible |
| Skin cancer screenings when provider bills as preventive | 100% | 60%, after deductible |
| Obesity or health diet counseling | 100% | 60%, after deductible |
| Screening and counseling services for misuse of alcohol or drugs | 100% | 60%, after deductible |
| Screening and counseling services to stop using tobacco products | 100% | 60%, after deductible |
| Sexually transmitted infection counseling | 100% | 60%, after deductible |
| **Physician Services** | | |
| Office visits<br>■ Primary care physician (PCP)<br>■ Specialty care physician<br>(Includes X-ray and lab work when performed and billed by the physician's office)<br>Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type | ■ PCP: $40 copay; deductible doesn't apply<br>■ Specialists: (Aetna) $80 copay/(Kaiser) $50 copay; deductible doesn't apply | 60%, after deductible |
| Telemedicine (Teladoc) – Available with the Aetna plans only | $40 copay; deductible doesn't apply | |
| Surgery (physician's office) | 80%, after deductible | 60%, after deductible |
| Allergy injections/antigens/serum<br>Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance. | Aetna: 80%, after deductible; no copay<br>Kaiser: $15 copay | 60%, after deductible |
| Allergy testing and treatment (dispensed by physician's office)<br>Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit. | Aetna: 100% after applicable PCP or specialist copay; deductible doesn't apply<br>Kaiser: Applicable specialist copay applies | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| **Hospital Services** | | |
| Inpatient hospital care (semi-private room) | 80%, after deductible | 60%, after deductible |
| Inpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Inpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Outpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Outpatient facility services<br>Office/ambulatory surgery center PCP and specialist copay will apply based on provider status | 80%, after deductible | 60%, after deductible |
| Outpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility) | 80%, after deductible | 60%, after deductible |
| **Maternity Care (Employee and dependent daughters)** | | |
| Physician's office (initial visit) | Aetna: $80 copay; deductible doesn't apply<br>Kaiser: 100% | 60%, after deductible |
| Physician's office (visits) | 100% | 60%, after deductible |
| Physician services (pre- and post-natal visits, delivery) | 80%, after deductible | 60%, after deductible |
| **Mental Health and Substance Abuse** | | |
| Inpatient services (facility, professional and other inpatient services) | 80%, after deductible | 60%, after deductible |
| Outpatient (individual or group therapy office visit) | $40 copay; deductible doesn't apply | 60%, after deductible |
| Outpatient services (facility, professional and other outpatient services) | 80%, after deductible | 60%, after deductible |
| **Emergency Services** | | |
| Ambulance | 80%, after deductible | 80%, after deductible |
| Emergency room<br>(waived if admitted) | 80%, after deductible | 80%, after deductible |
| Urgent care | Aetna: 80%, after deductible<br>Kaiser: $40 copay; deductible doesn't apply | Aetna: 60%, after deductible<br>Kaiser: $40 copay; deductible doesn't apply |
| **Other Services** | | |
| Abortion/Voluntary Sterilization (dependents covered) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Acupuncture<br>(Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year) | ■ Office visit: $80 copay; deductible doesn't apply<br>■ Other covered services: 80%, after deductible | 60%, after deductible |
| Autism and ABA Therapy | $40 copay; deductible doesn't apply | 60%, after deductible |
| Bariatric surgery<br>(One per lifetime; no dollar limit) | 80%, after deductible | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| Chiropractic care<br>(60 visits per calendar year) | $80 copay; deductible doesn't apply | 60%, after deductible |
| Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Diagnostic X-ray & lab | 80%, after deductible | 60%, after deductible |
| Durable medical equipment | Aetna: 80%, after deductible<br>Kaiser: 80%; deductible doesn't apply | 60%, after deductible |
| Genetic testing | 80%, after deductible | 60%, after deductible |
| Hearing aids (testing and exam) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Hearing aids (hardware - $1,000 per ear per calendar year) | 80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit) | 60%, after deductible |
| Home health care<br>(120 visits per calendar year) | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Hospice services | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Skilled nursing care (inpatient—120 days per calendar year) | 80%, after deductible | 60%, after deductible |
| Private duty nursing (outpatient—60 visits per calendar year) | 80%, after deductible | 60%, after deductible |
| Organ transplants:<br>■ Centers of Excellence<br>■ Non Centers of Excellence | <br>■ 80%, after deductible<br>■ 60%, after deductible | <br>■ N/A<br>■ 60%, after deductible |
| Prosthetic devices | 80%, after deductible | 60%, after deductible |
| Outpatient rehabilitative therapy | Aetna: $80 copay; deductible doesn't apply<br>Kaiser: $40 copay; deductible doesn't apply | 60% after deductible |
| Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis) | $80 copay in the physician's office; deductible and coinsurance in other places of service | 60% after deductible |

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

## $1,850 DEDUCTIBLE PLAN WITH HSA

| | In-Network | Out-of-Network* |
|---|---|---|
| **Annual Deductible** | | |
| ■ Individual | ■ $1,850 | ■ $3,700 |
| ■ Family | ■ $3,700 | ■ $7,400 |
| **Coinsurance for most covered services** | 80%, after deductible | 60%, after deductible |
| **Annual Out-of-Pocket Maximum**** | | |
| ■ Individual | ■ $3,500 | ■ $7,000 |
| ■ Family | ■ $6,500 | ■ $13,000 |
| **Lifetime Maximum** | None | |
| **Preventive Care** | | |
| Routine care and office visits (includes X-ray and lab work when billed as preventive care) | 100% | 60%, after deductible |
| Immunizations:<br>(including travel immunizations and flu shots) | | |
| ■ Children through age 2 | 100% | 60%, after deductible |
| ■ Children age 3 and over and adults | 100% | 60%, after deductible |
| Mammograms*** | 100% | 60%, after deductible |
| Pap smears | 100% | 60%, after deductible |
| Other routine cancer screenings | 100% | 60%, after deductible |
| Skin cancer screenings when provider bills as preventive | 100% | 60%, after deductible |
| Obesity or health diet counseling | 100% | 60%, after deductible |
| Screening and counseling services for misuse of alcohol or drugs | 100% | 60%, after deductible |
| Screening and counseling services to stop using tobacco products | 100% | 60%, after deductible |
| Sexually transmitted infection counseling | 100% | 60%, after deductible |
| **Physician Services** | | |
| Office visits<br>■ Primary care physician (PCP)<br>■ Specialty care physician<br>(Includes X-ray and lab work when performed and billed by the physician's office)<br>Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type | 80%, after deductible | 60%, after deductible |
| Telemedicine (Teladoc) – Available with the Aetna plans only | $40 copay until deductible is met; then 80% coinsurance | |
| Surgery (physician's office) | 80%, after deductible | 60%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| Allergy injections/antigens/serum<br>Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance. | 80%, after deductible | 60%, after deductible |
| Allergy testing and treatment (dispensed by physician's office)<br>Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit. | 80%, after deductible | 60%, after deductible |
| **Hospital Services** | | |
| Inpatient hospital care<br>(semi-private room) | 80%, after deductible | 60%, after deductible |
| Inpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Inpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Outpatient physician's visits/consultations | 80%, after deductible | 60%, after deductible |
| Outpatient facility services<br>Office/ambulatory surgery center PCP and specialist copay will apply based on provider status | 80%, after deductible | 60%, after deductible |
| Outpatient professional services (surgeon, radiologist, etc.) | 80%, after deductible | 60%, after deductible |
| Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility) | 80%, after deductible | 60%, after deductible |
| **Maternity Care (Employee and dependent daughters)** | | |
| Physician's office (visits) | Aetna: 80%, after deductible<br>Kaiser: 100% (pre-natal); 80%, after deductible (post-natal) | 60%, after deductible |
| Physician services (delivery) | 80%, after deductible | 60%, after deductible |
| **Mental Health and Substance Abuse** | | |
| Inpatient services (facility, professional and other inpatient services) | 80%, after deductible | 60%, after deductible |
| Outpatient (individual or group therapy office visit) | 80%, after deductible | 60%, after deductible |
| Outpatient services (facility, professional and other outpatient services) | 80%, after deductible | 60%, after deductible |
| **Emergency Services** | | |
| Ambulance | 80%, after deductible | 80%, after deductible |
| Emergency room<br>(waived if admitted) | 80%, after deductible | 80%, after deductible |
| Urgent care | 80%, after deductible | Aetna: 60%, after deductible<br>Kaiser: 80%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| **Other Services** | | |
| Abortion/Voluntary Sterilization (dependents covered) | 80%, after deductible | 60%, after deductible |
| Acupuncture<br>(Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year) | 80%, after deductible | 60%, after deductible |
| Autism and ABA Therapy | 80%, after deductible | 60%, after deductible |
| Bariatric surgery<br>(One per lifetime; no dollar limit) | 80%, after deductible | 60%, after deductible |
| Chiropractic care<br>(60 visits per calendar year) | 80%, after deductible | 60%, after deductible |
| Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances) | 80%, after deductible | 60%, after deductible |
| Diagnostic X-ray & lab | 80%, after deductible | 60%, after deductible |
| Durable medical equipment | 80%, after deductible | 60%, after deductible |
| Genetic testing | 80%, after deductible | 60%, after deductible |
| Hearing aids (testing and exam) | 80%, after deductible; subject to office visit copays | 60%, after deductible |
| Hearing aids (hardware - $1,000 per ear per calendar year) | 80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit) | 60%, after deductible |
| Home health care<br>(120 visits per calendar year) | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Hospice services | Aetna: 80%, after deductible<br>Kaiser: 100% | 60%, after deductible |
| Skilled nursing care (inpatient—120 days per calendar year) | 80%, after deductible | 60%, after deductible |
| Private duty nursing (outpatient—60 visits per calendar year) | 80%, after deductible | 60%, after deductible |
| Organ transplants:<br>■ Centers of Excellence<br>■ Non Centers of Excellence | <br>■ 80%, after deductible<br>■ 60%, after deductible | <br>■ N/A<br>■ 60%, after deductible |
| Prosthetic devices | 80%, after deductible | 60%, after deductible |
| Outpatient rehabilitative therapy | 80%, after deductible | 60%, after deductible |
| Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis) | 80%, after deductible | 60%, after deductible |

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

## $2,850 DEDUCTIBLE PLAN WITH HSA

| | In-Network | Out-of-Network* |
|---|---|---|
| **Annual Deductible** | | |
| ■ Individual | ■ $2,850 | ■ $5,700 |
| ■ Family | ■ $5,700 | ■ $11,400 |
| **Coinsurance for most covered services** | 70%, after deductible | 50%, after deductible |
| **Annual Out-of-Pocket Maximum**** | | |
| ■ Individual | ■ $5,500 | ■ $11,000 |
| ■ Family | ■ $11,000 | ■ $22,000 |
| **Lifetime Maximum** | None | |
| **Preventive Care** | | |
| Routine care and office visits (includes X-ray and lab work when billed as preventive care) | 100% | 50%, after deductible |
| Immunizations:<br>(including travel immunizations and flu shots) | | |
| ■ Children through age 2 | 100% | 50%, after deductible |
| ■ Children age 3 and over and adults | 100% | 50%, after deductible |
| Mammograms*** | 100% | 50%, after deductible |
| Pap smears | 100% | 50%, after deductible |
| Other routine cancer screenings | 100% | 50%, after deductible |
| Skin cancer screenings when provider bills as preventive | 100% | 50%, after deductible |
| Obesity or health diet counseling | 100% | 50%, after deductible |
| Screening and counseling services for misuse of alcohol or drugs | 100% | 50%, after deductible |
| Screening and counseling services to stop using tobacco products | 100% | 50%, after deductible |
| Sexually transmitted infection counseling | 100% | 50%, after deductible |
| **Physician Services** | | |
| Office visits<br>■ Primary care physician (PCP)<br>■ Specialty care physician<br>(Includes X-ray and lab work when performed and billed by the physician's office)<br>Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type | 70%, after deductible | 50%, after deductible |
| Telemedicine (Teladoc) – Available with the Aetna plans only | $40 copay until deductible is met; then 80% coinsurance | |
| Surgery (physician's office) | 70%, after deductible | 50%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| Allergy injections/antigens/serum<br>Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance. | 70%, after deductible | 50%, after deductible |
| Allergy testing and treatment (dispensed by physician's office)<br>Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit. | 70%, after deductible | 50%, after deductible |
| **Hospital Services** | | |
| Inpatient hospital care<br>(semi-private room) | 70%, after deductible | 50%, after deductible |
| Inpatient physician's visits/consultations | 70%, after deductible | 50%, after deductible |
| Inpatient professional services (surgeon, radiologist, etc.) | 70%, after deductible | 50%, after deductible |
| Outpatient physician's visits/consultations | 70%, after deductible | 50%, after deductible |
| Outpatient facility services<br>Office/ambulatory surgery center PCP and specialist copay will apply based on provider status | 70%, after deductible | 50%, after deductible |
| Outpatient professional services (surgeon, radiologist, etc.) | 70%, after deductible | 50%, after deductible |
| Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility) | 70%, after deductible | 50%, after deductible |
| **Maternity Care (Employee and dependent daughters)** | | |
| Physician's office (visits) | Aetna: 70%, after deductible<br>Kaiser: 100% | 50%, after deductible |
| Physician services (delivery) | 70%, after deductible | 50%, after deductible |
| **Mental Health and Substance Abuse** | | |
| Inpatient services (facility, professional and other inpatient services) | 70%, after deductible | 50%, after deductible |
| Outpatient (individual or group therapy office visit) | 70%, after deductible | 50%, after deductible |
| Outpatient services (facility, professional and other outpatient services) | 70%, after deductible | 50%, after deductible |
| **Emergency Services** | | |
| Ambulance | 70%, after deductible | 70%, after deductible |
| Emergency room<br>(waived if admitted) | 70%, after deductible | 70%, after deductible |
| Urgent care | 70%, after deductible | 50%, after deductible |

| | In-Network | Out-of-Network* |
|---|---|---|
| **Other Services** | | |
| Abortion/Voluntary Sterilization (dependents covered) | 70%, after deductible | 50%, after deductible |
| Acupuncture<br>(Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year) | 70%, after deductible | 50%, after deductible |
| Autism and ABA Therapy | 70%, after deductible | 50%, after deductible |
| Bariatric surgery<br>(One per lifetime; no dollar limit) | 70%, after deductible | 50%, after deductible |
| Chiropractic care<br>(60 visits per calendar year) | 70%, after deductible | 50%, after deductible |
| Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances) | 70%, after deductible | 50%, after deductible |
| Diagnostic X-ray & lab | 70%, after deductible | 50%, after deductible |
| Durable medical equipment | 70%, after deductible | 50%, after deductible |
| Genetic testing | 70%, after deductible | 50%, after deductible |
| Hearing aids (testing and exam) | 70%, after deductible; subject to office visit copays | 50%, after deductible |
| Hearing aids (hardware - $1,000 per ear per calendar year) | 70%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit) | 50%, after deductible |
| Home health care<br>(120 visits per calendar year) | 70%, after deductible | 50%, after deductible |
| Hospice services | 70%, after deductible | 50%, after deductible |
| Skilled nursing care (inpatient—120 days per calendar year) | 70%, after deductible | 50%, after deductible |
| Private duty nursing (outpatient—60 visits per calendar year) | 70%, after deductible | 50%, after deductible |
| Organ transplants:<br>■ Centers of Excellence<br>■ Non Centers of Excellence | <br>■ 70%, after deductible<br>■ 50%, after deductible | <br>■ N/A<br>■ 50%, after deductible |
| Prosthetic devices | 70%, after deductible | 50%, after deductible |
| Outpatient rehabilitative therapy | 70%, after deductible | 50%, after deductible |
| Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis) | 70%, after deductible | 50%, after deductible |

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

# COVERED SERVICE DESCRIPTIONS

This section describes the services highlighted in "Benefits Covered by the Medical Plan" beginning on page 45.

## PREVENTIVE CARE

The Medical Plan uses prevailing clinical standards to determine preventive care guidelines. The plan covers preventive care services, which include:

### Well Child Care

These services are covered for each covered child through age two including periodic assessments and immunizations.

### Women's Preventive Health Care

Women's preventive health care is covered at 100%, including oral contraceptives (generic and brand name), contraceptive devices and implants.

### Routine Physical Exams

Routine physical exams, health care assessments, wellness visits and any related services will be covered for each covered individual age three and older (including immunizations). A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes radiological services and X-rays.

### Immunizations

The full series of standard immunizations recommended by the Department of Health. Covered immunizations include, but are not limited to, the following:

- Diphtheria Pertussis Tetanus Toxoid (DPT).
- HiB.
- Polio.
- Hepatitis A and B.
- Measles Mumps Rubella (MMR).
- Meningococcal vaccine.
- Chicken pox.
- Pneumococcal vaccine.
- Rotavirus.
- Human papillomavirus.
- Flu vaccines.

### Cancer Screenings

Covered expenses include charges incurred for routine cancer screenings and related office visits.

- **Gynecological exam, including cervical cancer screening:** The cervical cancer screening benefit includes an exam and laboratory tests for early detection and screening of cervical cancer, and the doctor's interpretation of the lab results. Coverage for cervical cancer screening includes a Pap smear screening, liquid based cytology and human papilloma virus detection and should follow the American Cancer Society guidelines.
- **Screening mammograms:** Screening mammograms are covered along with a doctor's interpretation of the results. In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.
- **Prostate screening:** Prostate Specific Antigen (PSA) tests or equivalent serological tests are covered.
- **Colorectal cancer screenings** including:
  - Fecal occult blood test (including a digital rectal examination (DRE)).
  - Flexible sigmoidoscopy (including a DRE).
  - Fecal occult blood test plus flexible sigmoidoscopy (including a DRE).
  - Double contrast barium enema (including a DRE).
  - Colonoscopy (including a DRE).
  - Lung cancer screenings.
- **Skin cancer screenings and other standard cancer screenings.**

### Additional Services

- **Obesity or health diet counseling:** Preventive counseling visits, nutritional counseling, healthy diet counseling visits for members with high cholesterol. For members 22 and older, the maximum annual visits is 26 with no more than 10 visits for healthy diet counseling. There is no visit limit for members under age 22.
- **Screening for misuse of alcohol or drugs:** Preventive counseling visits, risk factor reduction intervention and a structured assessment. Maximum of five (5) visits per member per year. A 60-minute session is equal to one visit.

- **Screening for use of tobacco products:** Preventive counseling visits, treatment visits and class visits. When prescribed by a physician FDA- approved prescription drugs and over the counter drugs to help stop the use of tobacco products.
- **Sexually transmitted infection counseling:** Eligible services include counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk of counseling for breast and ovarian cancer:** Eligible services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.
- **Lactation support and counseling services:** Eligible services include assistance and training in breastfeeding from a certified lactation support provider.
- **Breast pump:** The purchase of an electric breast pump once every three years or the purchase of a manual breast pump once per pregnancy.

## PHYSICIAN SERVICES

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility.

Covered services also include:

- Care such as consultations and second surgical opinions.
- Office surgery.
- Radiological services, X-rays and tests.
- Medical supplies.
- Allergy treatment/injections and allergy serums.
- Assistant surgeon and co-surgeon charges:
  - The maximum amount payable will be limited to charges made by an assistant surgeon that does not exceed a percentage of the surgeon's allowable charge as specified in Aetna or Kaiser Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
  - The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Aetna or Kaiser Reimbursement Policies.

## HOSPITAL/FACILITY SERVICES

### Inpatient Hospital Services

The plan provides coverage when you are admitted to a hospital as an inpatient. If you are admitted before the effective date of coverage, benefits will not be available for services received prior to the effective date. If you are in the hospital as an inpatient at the time you begin a new benefit period, you may have to meet a new deductible for covered services from doctors or other professional providers. You should work with your doctor to make sure pre-certification has been requested. Pre-certification must be obtained in advance from Aetna or Kaiser or your benefits may be reduced or denied.

Covered services include:

- Medical care provided by a doctor or other professional provider.
- Room and board at the hospital's current rate for a semi-private room. Private rooms are paid up to the cost of a semi-private room.
- Use of the operating room, delivery room, recovery room, nursery and related services.
- General nursing care.
- Special care units (e.g., intensive care or critical care) at the plan's negotiated rate for in-network care and the daily room rate for out-of-network care.
- Drugs administered by the hospital.
- Diagnostic services and medical supplies.
- Use of appliances and equipment ordinarily provided by the hospital.
- Short-term rehabilitative therapies and other therapies.

### Outpatient Services

Benefits are provided for outpatient services received in a hospital, a hospital-based facility or an outpatient clinic.

Covered services include:

- Medical care provided by a doctor or other professional provider.
- General nursing care.
- Drugs administered by the facility.
- Diagnostic services.
- Medical supplies.
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of outpatients.

- Operating room, observation room, recovery room and related services (outpatient surgery).
- Short-term rehabilitative therapies and other therapies.

### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

### Other Health Care Facilities

The plan provides benefits for covered services received in other health care facilities including a skilled nursing facility, rehabilitation hospital or sub-acute facility for medical care and treatment. You should work with your doctor to make sure pre-certification has been requested. Pre-certification must be obtained in advance from Aetna or Kaiser or your benefits may be reduced or denied. Skilled nursing facility services are limited to a combined in-network and out-of-network maximum of 120 days per calendar year. Except for any day of confinement, covered expenses exclude charges that exceed the daily limit.

## MATERNITY CARE

Maternity care benefits are available to covered employees and dependent daughters. Maternity care includes prenatal care, labor and delivery and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Labor and delivery services for mother and newborn received during an inpatient hospital stay are covered. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy.

### Delivery

The plan covers an inpatient hospital stay for the mother and her newborn for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without pre-certification by Aetna or Kaiser. However, the plan may pay for a shorter stay if the attending provider (e.g., your doctor or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a home health visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, pre-certification is required for inpatient stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section.

### Newborn Care

Inpatient newborn care of a well baby, excluding pediatric and specialty physician charges, is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This inpatient newborn care (well baby) requires only one benefit period deductible for both mother and baby. Benefits also include newborn hearing screening ordered by a doctor to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether inpatient (sick baby) or outpatient, the newborn must be enrolled for coverage as a dependent child. At this time, the baby must meet the individual benefit period deductible if applicable and pre-certification are required to avoid a penalty.

### Termination of Pregnancy (Abortion)

Benefits for abortion include elective and non-elective procedures, or when the life of the mother is in danger.

## MENTAL HEALTH SERVICES

Covered expenses include charges made for the treatment of mental disorders that impairs behavior, emotional reaction or thought processes. Expenses for the treatment of any physiological conditions related to mental health are not covered.

### Inpatient Care

Benefits are payable for charges incurred in a hospital (including partial hospitalization) and residential treatment facility for the treatment and evaluation of mental health. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your admission. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

The plan covers partial hospitalization services (more than four hours, but less than 12 hours in any 24-hour period). The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Two days of residential treatment services are billed at the same rate as one day of hospital treatment.

Remember, you or your provider must call Aetna or Kaiser for pre-certification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

### Outpatient Care

Covered expenses include charges for treatment received while not confined in a hospital or residential treatment facility. Coverage includes treatment in an individual, group or mental health intensive outpatient therapy program.

## SUBSTANCE ABUSE SERVICES

Covered expenses include charges made for the treatment of the psychological and physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment. Expenses for the treatment of any physiological conditions related to rehabilitation services for alcohol, drug abuse or addiction are not covered.

### Inpatient Care

Benefits are payable for charges incurred in a hospital (including partial hospitalization) and residential treatment facility for the treatment of substance abuse or addiction to alcohol and/or drugs. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your admission. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

The plan covers partial hospitalization services (more than four hours, but less than 12 hours in any 24-hour period). The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Two days of residential treatment services are billed at the same rate as one day of hospital treatment.

Remember, you or your provider must call Aetna or Kaiser for pre-certification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

### Outpatient Care

Covered expenses include charges for treatment received while not confined in a hospital or residential treatment facility. Coverage includes outpatient rehabilitation in an individual or substance abuse intensive outpatient therapy program.

## EMERGENCY AND URGENT CARE

In the case of an emergency, the plan provides benefits for emergency services.

An emergency is the sudden and unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of emergencies.

### What to Do in an Emergency

In an emergency, you should seek care from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life threatening emergencies.

Pre-certification is not required for emergency services. Your visit to the emergency room will be covered if your condition meets the definition of an emergency.

### Care Following Emergency Services

In order to receive in-network benefits for follow-up care related to the emergency (such as office visits or therapy once you left the emergency room or were discharged from the hospital), you must use in-network providers. Follow-up care related to the emergency condition is not considered an emergency and will be treated the same as a normal health care benefit.

### Urgent Care

The plan also provides benefits for urgent care services. Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the member could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent. When you need urgent care, call your physician, a specialist or go to an urgent care provider.

### Ambulance Services

The plan covers services for licensed ambulance services to or from the nearest hospital where the needed medical care and treatment can be provided. Non-emergency ambulance transfers that do not either begin or end at a hospital are not covered.

## OTHER SERVICES

### Acupuncture

This plan covers medically necessary acupuncture for adults for any of the following conditions:

- Nausea and vomiting associated with pregnancy.
- Nausea and vomiting associated with chemotherapy.
- Postoperative nausea and vomiting.
- Postoperative dental pain.
- Limited other chronic painful conditions when used as an adjunct to standard therapy.

Contact Aetna or Kaiser for details and restrictions.

### Autism and Applied Behavior Analysis

The plan covers services and supplies for the diagnosis and treatment of Autism Spectrum Disorders prescribed by a physician or other behavioral health provider with no annual maximum such as Applied Behavior Analysis (ABA). ABA is an educational service that is the process of applying intensive behavioral interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

### Bariatric Surgery

The plan provides coverage for bariatric surgery (including procedures to adjust or reverse bariatric surgery). Bariatric surgery, or weight loss surgery, is surgery to reduce the size of the stomach through any of the following:

- An implanted medical device.
- Removal of a portion of the stomach.
- Resecting and re-routing the small intestines to a small stomach pouch.

Coverage for bariatric surgery is based upon specific criteria outlined in Aetna's or Kaiser's Coverage Policy for Bariatric Surgery. Contact Aetna or Kaiser for details and restrictions prior to receiving services.

### Bariatric Surgery Exclusions

The Plan does not cover bariatric surgery procedures that are not considered medically necessary, or that are deemed experimental, investigational or unproven. Please contact Aetna or Kaiser for details. Some excluded procedures include (but are not limited to):

- Roux-en-Y gastric bypass (when combined with simultaneous banding)
- Gastroplasty (stomach stapling)
- Intestinal bypass (jejunoieal bypass)
- Intragastric balloon
- Loop gastric bypass
- Mini-gastric bypass
- Vagus nerve blocking
- Vagus nerve stimulation

### Chiropractic Care

Charges made for diagnostic and treatment services used in an office setting by chiropractic physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment of specific joints to restore motion, reduce pain and improve function.

- Benefits are limited to a combined in- and out-of-network calendar year maximum of 60 days per person.

### Chiropractic Care Exclusions

- Occupational therapy provided for purposes other than enabling persons to perform the activities of daily living after an injury or sickness.

- Services of a chiropractor which are not within his scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.
- Vitamin therapy.

## Clinical Trials

The plan provides benefits for routine patient care as the result of a phase II, III and IV clinical trial for the purposes of prevention, early detection or treatment of cancer, if approved by one of the following entities, and the treating facility and personnel have the expertise and training to provide the treatment and treat a sufficient number of patients:

- The National Institutes of Health (NIH), including an NIH cooperative group or center, or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center, Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA).
- Conducted under an investigational new drug application (IND) reviewed by the FDA, or an investigational new drug exemption as defined by the FDA.
- For phase II clinical trials, the person is enrolled in the Phase II clinical trial, not merely following protocol of a Phase II clinical trial.
- A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Routine patient care costs are defined as follows:

- Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's particular condition.
- Reasonable and medically necessary services needed to administer a drug or device under evaluation in a clinical trial.
- All services and supplies required for the diagnosis and treatment of complications as a result of the cancer trial.

The plan covers participation in Clinical Trials as described above at all Commission on Cancer-approved facilities and cancer centers designated by the NCI.

### Clinical Trial Exclusions

- Investigational item or service itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

## Dental Treatment Covered Under Your Medical Benefit

The plan provides coverage for:

- Charges made for a continuous course of dental treatment started within 12 months of an injury to sound, natural teeth.
- Dental implants to repair defects in the jaw due to a removed tumor/cyst, severe atrophy in a toothless arch, exposed nerves, non-union of a jaw fracture, loss of a tooth/teeth due to an accidental injury or a birth defect diagnosed within 31 days of birth.
- Medically necessary surgical treatment of Temporomandibular joint (TMJ) disease (on a limited, case by case basis).
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthotics alone cannot correct.

### Dental Treatment Not Covered Under Your Medical Benefit

- Orthodontic braces.
- Dentures and dental implants.
- Crowns and bridges.
- Treatment for periodontal disease.
- Extractions.
- Dental root form implants or root canals.
- Injury related to chewing or biting.
- No other dental services.

## Diagnostic Services

Diagnostic procedures help your physician find the cause and extent of your condition in order to plan for your care. Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.

Separate benefits for the interpretation of diagnostic services by the attending doctor are not provided. In addition, benefits for that doctor's medical or surgical services are not included, except as otherwise determined by Aetna or Kaiser, as applicable.

## Durable Medical Equipment

Benefits are provided for durable medical equipment and supplies required for operation of equipment when prescribed by a doctor. Equipment may be purchased or rented at the discretion of the plan. The plan provides benefits for repair or replacement of the covered equipment. Benefits will end when the equipment is no longer medically necessary. Certain durable medical equipment requires pre-certification or services will not be covered.

Examples of covered durable medical equipment include:

- Wheel chairs.
- Hospital beds.
- Crutches.
- Respiratory (inhalation) or suction and dialysis machines.

### Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience.
- Repair or replacement of equipment due to abuse or desire for new equipment.

## Family Planning

Benefits are provided for family planning including physical exams, related laboratory tests, medical supervision in accordance with generally accepted medical practices and other medical services.

### Contraception

Contraception devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) and diaphragms are covered at 100% as mandated by the Patient Protection and Affordable Care Act (PPACA).

### Sterilization

Sterilization includes female tubal ligation and male vasectomy.

### Infertility and Sexual Dysfunction Services

Covered services include:

- Testing and treatment performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g., procedures to correct an infertility condition).

### Family Planning Exclusions

- Infertility drugs.
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures.
- Reversal of male and female voluntary sterilization.
- Infertility services when the infertility is caused by or related to voluntary sterilization.
- Donor charges and services.
- Cryopreservation of donor sperm and eggs.
- Any experimental, investigational or unproven infertility procedures or therapies.

## Gender Reassignment Counseling, Surgery and Injectable Hormone Replacement Therapy

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person. IQVIA follows the recommendations of the World Professional Association for Transgender Health, treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

## Genetic Testing

Benefits are provided for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

Coverage for genetic testing is based upon specific criteria outlined in Aetna's or Kaiser's Coverage Policy for Genetic Testing. Contact Aetna or Kaiser for details and restrictions prior to receiving services.

## Hearing Aids

Hearing aids are covered at the applicable coinsurance after the deductible up to a $1,000 benefit maximum per ear once per calendar year.

## Home Health Care

Home health care services are covered by the plan if you require skilled care, cannot obtain the required care as an ambulatory outpatient and do not require inpatient treatment at a hospital or other health care facility.

Home health care, including nursing and home infusion, requires pre-certification or services will not be covered. Coverage for home health care expenses is limited to a combined in- and out-of-network maximum of 120 visits per calendar year.

Benefits will be provided for:

- Professional services of a registered nurse (RN) or licensed practical nurse (LPN) for visits totaling 16 hours a day. Multiple visits can occur in one day, with a visit defined as a period of two hours or fewer. Outpatient private duty nursing is covered when approved as medically necessary.
- Short-term rehabilitative therapies (subject to the benefit limits described under "Therapies").
- Medical supplies and home infusion therapy.
- Oxygen and its administration.
- Medical social service consultations.
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services.

### Home Health Care Exclusions

- Services that are provided by a close relative or a member of your household.

## Hospice Services

Your coverage provides benefits for hospice services for care of a terminally ill covered individual with a life expectancy of six months or fewer. Hospice services are covered only as part of a licensed health care program that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families. A hospice care program is centrally coordinated through an interdisciplinary team directed by a doctor.

Covered services include:

- Bed, board, services and supplies at an inpatient hospice facility.
- Outpatient services at a hospice facility.
- Professional services of a physician.
- Counseling from a psychologist, social worker, family counselor or ordained minister for individual or family counseling.
- Bereavement counseling.
- Pain relief treatment, including drugs, medicines and medical supplies.
- Part-time care under the supervision of a nurse or a health care professional.
- Physical, occupational and speech therapy.

### Hospice Services Exclusions

- Services that are provided by a close relative or a member of your household.
- Services and supplies that are primarily to aid you in daily living.

## Laboratory, Radiology and Other Diagnostic Testing

Laboratory studies are services such as diagnostic blood, urine tests or an examination of biopsied tissue (i.e., tissue removed from your body by a surgical procedure). Radiology services are diagnostic imaging procedures such as X-rays, ultrasounds, computed tomographic (CT) scans and magnetic resonance imaging (MRI) scans.

Other diagnostic testing includes electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs). Certain diagnostic imaging procedures, such as CT scans and MRIs, require Pre-certification or services will not be covered.

## Organ Transplants

The plan provides benefits for transplants, including solid organ and bone marrow/stem cell procedures for the transplants listed below. Covered services include medical, surgical and hospital services, medications and the cost for organ or bone marrow/stem cell procurement.

- Cornea.
- Heart.
- Simultaneous pancreas and kidney.
- Lung, single and bilateral.
- Liver.
- Combined heart and lung.

- Intestine: Small bowel or multi-visceral.
- Pancreas.
- Simultaneous small bowel and liver.
- Kidney.
- Simultaneous liver and kidney.
- Allogenic and autologous bone marrow transplants.

Transplant services are covered at 80% in the $400, $900 and $1,850 Deductible Plans and 70% in the $2,850 Deductible Plan, after the medical plan deductible if you use a Center of Excellence. Services are covered at 60% in the $400, $900 and $1,850 Deductibles Plans and 50% in the $2,850 Deductible Plan, after the medical plan deductible if you use a non-Center of Excellence.

Benefits are also provided for reasonable travel expenses when a covered member travels a distance of 100 miles or greater for a pre-approved organ/tissue transplant (excluding cornea) performed at a Center of Excellence. A maximum travel benefit of $10,000 per transplant per lifetime is provided. Coverage varies by the plan. Lodging is covered up to $50 per day for one person staying alone or up to $100 per day for two people. Food and meals are not covered.

Pre-certification must be obtained in advance from Aetna or Kaiser for all transplant related services or your benefits may be reduced or denied.

### Transplants Exclusions

- Transplants that are considered experimental or investigational.
- Services, drugs and supplies for or related to transplants, except those transplants specifically listed as covered services.

## Overseas Care (Emergency and Non-Emergency)

If you are traveling overseas for a short-term visit (non-Expat), your Aetna or Kaiser plan will provide emergency coverage, it will not cover routine care.

If you are an eligible Expat, you will be covered under the Aetna International Plan. Coverage is provided for in-network and out-of–network care, as well as for care received outside of the U.S. While no annual deductible applies outside of the U.S., there is an out-of-network deductible inside the U.S. There is also an out-of-pocket maximum for in-network and out-of-network services received in the U.S. Coverage for Expats under the Aetna International Plan differs from coverage provided under the plans described in this SPD. Contact your benefits representative for details.

## Prosthetic Appliances

### External Devices

The plan provides benefits for the initial purchase and fitting of medically necessary external prosthetic appliances and devices prescribed by a doctor. Coverage is limited to the most appropriate and cost effective alternatives as determined by the utilization review physician. External prosthetic appliances and devices include prostheses/prosthetic appliances and devices, orthoses/orthotic devices (including custom foot and other orthoses), braces and splints.

### Internal Devices

The plan provides benefits for internal prosthetic/medical appliances that provide permanent or temporary internal functional support for non-functional body parts. Medically necessary repair, maintenance or replacement of a covered appliance is also covered.

## Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) is covered if:

- The surgery or therapy restores or improves function.
- Reconstruction is required as a result of medically necessary, non-cosmetic surgery. (Includes breast reduction surgery with supported medical documentation.)
- The surgery or therapy is performed before age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.
- Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review physician.

## Rehabilitative Therapies

The plan provides coverage for the following therapy services to promote the recovery from an illness, disease or injury. A doctor or other professional provider must order these services.

### Short-Term Rehabilitative Therapies

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac therapy, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

In network therapy, days are provided as part of an approved home health care plan and accumulate to the short-term rehabilitative therapy maximum. If multiple outpatient services are provided on the same day, the services count as having been received on one day.

- Please note that occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an illness, injury or sickness.

*Therapy Exclusions*

Short-term rehabilitative therapy services that are not covered include, but are not limited to:

- Sensory integration therapy, group therapy, treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder.
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or a swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury.
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.

### Short-Term Rehabilitative Therapies (for covered members with a development delay diagnosis)

- Speech, physical, and occupational therapy are covered for Developmental Delays. However, occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

*Therapy Exclusions (for covered members with a development delay diagnosis)*

- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training; vocational rehabilitation; behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy; employment counseling, back to school, return-to-work services, work hardening programs; driving safety and services; training; educational therapy; or other non-medical ancillary services for learning disabilities.

### Telehealth Services

The IQVIA Plan includes coverage for telephone and online video consultations through Teladoc offered through Aetna. Teladoc connects you to a board-certified doctor by phone or online video chat 24 hours a day, seven days a week, 365 days a year. Teladoc doctors can treat many non-emergency conditions such as:

- Allergies
- Bronchitis
- Cold & Flu
- Ear Infections
- Sinus Infections
- Skin Inflammations
- Sports Injuries
- Urinary Tract Infections
- And More

You must register for the service either online at Teladoc.com/Aetna or call 855-Teladoc (835-2362).

## BENEFITS NOT COVERED BY THE MEDICAL PLAN

While the Medical Plan covers a wide variety of medically necessary services, there are some expenses that are not covered. Some of these are listed below.

Exclusions that apply to many services are listed in this section and in "Benefits Covered by the Medical Plan" beginning on page 45. In addition, the plan does not cover charges for services, supplies, drugs for the following:

- Care for health conditions that are required by state or local law to be treated in a public facility.

- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under your Medical Plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Aetna's or Kaiser's, as applicable, medical director to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use.
  - The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Other Services" beginning on page 62.
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Other Services" beginning on page 62.
  - Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Abdominoplasty, panniculectomy, redundant skin surgery, removal of skin tags, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Non-surgical treatment of TMJ disorder.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a participating physician or otherwise covered under "Benefits Covered by the Medical Plan."
- Infertility drugs, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia and premature ejaculation.
- Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under the Medical Plan.

- Non-medical counseling or ancillary services, including, but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety and services, training, educational therapy or other non-medical ancillary services.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services" or "Home Health Services" sections of "Benefits Covered by the Medical Plan" beginning on page 45.
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Benefits Covered by the Medical Plan" beginning on page 45.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs and investigational and experimental drugs, except as provided in "Benefits Covered by the Medical Plan" beginning on page 45.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in Aetna's or Kaiser's medical director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are medications for the purpose of travel or to protect against occupational hazards and risks. Travel immunizations are covered.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulas are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who was covered under the Medical Plan as a retiree, or his/her dependents, when payment is denied by the Medicare plan because treatment was not received from an in-network provider. Note that retiree medical coverage ends when the participant reaches age 65. There is no retiree medical coverage for terminated or retired employees age 65 or older.

- Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from an in-network provider of the primary plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations.
- Massage therapy.

**This list is subject to change at any time.**

# FILING A MEDICAL CLAIM

- Aetna: For in-network claims, the Aetna provider will handle claim filing on your behalf. To receive benefits from the plan for out-of-network covered medical expenses, you must file a claim form with Aetna and include the necessary supporting documentation. Separate claim forms must be submitted for each person filing a claim.

  Claim forms are available at www.aetna.com. To download a claim form, log in and click "Manage Claims".
- Kaiser: If you need a claim form to request payment or reimbursement for a covered service, or if you need help completing the form, call Kaiser Permanente at 1-800-464-4000 or go to https://healthy.kaiserpermanente.org.

Before you submit your claim form, make sure you include all the necessary information.

## APPEALING CLAIMS

If a claim for reimbursement under the Medical Plan is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Administrative Information* section.