

Amendment to Plan of Benefits

For Employees of: BANNER HEALTH

Master Services Agreement/Administrative Services Agreement/Administrative Services Contract No.: 285731

Effective January 1, 2022, the following changes have been made to your Booklet. These changes only apply to members in a medical plan that uses network providers. It does not apply to those members in a retiree only medical plan.

1. The following replaces the current definition now appearing in the Glossary section in your booklet.

Emergency services

Treatment given in a **hospital's** emergency room or an independent freestanding emergency department. This includes evaluation of and treatment to stabilize the **emergency medical condition**. An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

2. The following replaces the current definition now appearing in the Glossary section in your booklet.

Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose, or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

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

Generally accepted standards of medical practice means:

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

Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **experimental or investigational**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

3. The following replaces the current benefit now appearing in the Coverage and Exclusions section in your Booklet.

Emergency services

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

Covered services include only services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. For those plans that use a network of providers, you can get **emergency services** from network or **out-of-network providers**.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

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

Non-emergency services

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

4. The Recognized Charge section now appearing in the How Your Plan Works section in your booklet is revised as follows.

Voluntary Services

The amount of an **out-of-network provider's** charge that is eligible for coverage. You may be responsible for all amounts above what is eligible for coverage. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage (see *Involuntary Services and Surprise Bills* for more information).

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider** for whom we access NAP rates. Through NAP, the **recognized charge** is determined as follows:

- If your service was received from a NAP **provider**, a pre-negotiated charge **may** be paid. NAP **providers** are **out-of-network providers** that have contracts with Aetna, directly or through third-party vendors, that include a **pre-negotiated charge** for services. NAP **providers** are not **network providers**. (At times Aetna may choose to terminate specific providers from NAP and will notify the provider of such a decision).
- If your service was not received from a NAP **provider**, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the **recognized charge** for specific services or supplies will be the **out-of-network plan rate**, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
Professional services*	<p style="color: red; text-align: center;">THERE IS NO CHANGE TO YOUR OUT-OF-NETWORK PLAN RATE. PLEASE REFER TO YOUR CURRENT SPD LANGUAGE FOR THE PLAN RATE THAT APPLIES TO EACH OF THESE SERVICES.</p>
Inpatient and outpatient charges of hospitals*	
Inpatient and outpatient charges of facilities other than hospitals*	
Prescription drugs	

* *Involuntary services are not paid as outlined above. See [Involuntary Services and Surprise Bills](#) for information on how these claims are paid under the plan.*

Important note: If the **provider** bills less than the amount calculated using the **out-of-network plan rate** described above, the **recognized charge** is what the **provider** bills.

In the event you receive a balance bill from a **provider** for your out-of-network service, Patient Advocacy Services may be available to assist you in certain circumstances. If Patient Advocacy Services are available for your claim, additional information will be provided to you.

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

The out-of-network plan rate does not apply to involuntary services. See [Involuntary Services and Surprise Bills](#) for more information.

Special terms used

- Average wholesale price (AWP) is the current average wholesale price of a **prescription drug** listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
 - The method CMS uses to set Medicare rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services or do not consent to receive services from an **out-of-network provider**, even where you try to stay in the network for your **covered services**. You may then get a bill at a rate that you didn't expect. This is called a surprise bill. A federal law called the No Surprises Act protects you from surprise bills by limiting cost sharing and prohibiting balance billing by out of network providers.

An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and delivered in the Emergency Room or an independent freestanding emergency department. These services are covered through stabilization and in some cases include admission to the facility.
- Non emergency and surgical and ancillary services (defined below) provided by an **out-of-network provider** at an in-network facility by certain types of providers. Providers other than the types below may balance bill you if the **out-of-network provider** has given you the following:
 - The out-of-network notice for your signature
 - The estimated charges for the items and services
 - Notice that the **provider** is an **out-of-network provider**
 - Signed consent from you to be treated and balance-billed by the **out-of-network provider**
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:

- **Surgery**, including assistants
- Anesthesiology
- Pathology
- Radiology
- Hospitalist services
- Laboratory services
- Neonatology
- Emergency Medicine
- Other provider types as may be added under Federal Law

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation
- Other therapeutic health settings

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the **out-of-network provider** based on the median in-network rate or such other data resources or factors as determined by Aetna.

Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network **deductible** and out-of-pocket maximum, if you have one.

Certain **out-of-network** providers may ask you to sign a consent form to allow them to balance bill you for services above any amounts covered by your plan. In this case, you may be responsible for all charges from that out-of-network provider.

You may request external review if you are seeking to determine if the No Surprises Act applies to your situation.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

5. The following Keeping a provider or facility you go to now (continuity of care) section replaces the Keeping a provider you go to now (continuity of care) section now appearing in the How Your Plan Works section in your booklet.

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

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

- You join the plan and the **provider** or facility you have now is not in the network
- You are already an Aetna member and your **provider** or facility stops being in our network

However, in some cases, you may be able to keep going to your current **provider** or facility to complete a treatment or to have treatment that was already scheduled at the in-network cost sharing levels for up to 90 days of the provider or facility ceasing to be in our network. This is called continuity of care. If we know you are under an active treatment plan, we will notify you of the provider's or facility's contract termination and how you can submit a request to keep going to your current **provider** or facility. Contact us for additional information.

6. The following replaces the same section now appearing in the How Your Plan Works section in your booklet.

Providers

Our **provider network** is there to give you the care you need. You can find **network providers** and see important information about them by logging in to your member website. There you'll find our online provider directory. You may also ask contact us to ask for a copy of the directory. We update the online directory regularly, but the listings can change. Before you get care, we suggest that you call us for current information or to make sure that your provider, their office location, or their provider group is in the network. See the Contact us section for more information.

7. The following replaces **How we administer this plan** within Administrative Provisions now appearing in the General Provisions – Other Things You Should Know section in your booklet.

How Aetna administers this plan

Aetna will administer the Plan in accordance with this booklet and apply policies and procedures which Aetna has developed to administer this plan.

8. The following is added to Administrative Provisions now appearing in the General Provisions – Other Things You Should Know section in your booklet.

Aetna's authority as claim administrator

Aetna has been designated as claims administrator for benefits under the Plan with full discretion and authority to make claim and appeal determinations. The claims administrator is the appropriate named fiduciary of the plan for purposes of reviewing denied claims for benefits. In exercising this fiduciary responsibility, Aetna has full discretionary authority to make factual determinations, to determine eligibility for benefits, to determine the amount of benefits for each claim received, and to construe terms of the Plan with respect to benefits. Aetna's decisions are final and binding upon you and any person making a claim on your behalf. Your employer retains sole and complete authority to determine eligibility of persons to participate in the Plan.

Network Medical Plans

Aetna is full claim fiduciary – ERISA plans

Amend: 1787

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