Amendment to Plan of Benefits

For Employees of: AUSTIN INDEPENDENT SCHOOL DISTRICT
Master Services Agreement/Administrative Services Agreement/Administrative Services Contract No.: 737540

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 providersirEmpdrMCID 5dipdrMnly plapphlhan members .7 (e)-27usebe.7 (e) 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

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**

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

- **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. [illegible]