Amendment to Plan of Benefits

For Employees of: **HOUSTON ISD**
Administrative Services CONTRACT No.: ASC-620266

Effective January 1, 2013, the following changes have been made to your Booklet.

The group contract noted above has been changed. The following is a summary of the changes in the group contract, and the Booklet, which includes the contract terms, is also changed. This amendment is effective on the date shown above.

The following benefits are covered under your plan. These benefits are added to any like or similar benefits currently appearing in your Schedule of Benefits and Booklet.

Preventive Care

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

Many preventive and routine medical expenses are covered. This Preventive Care section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Important Notes:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force; and
   - Health Resources and Services Administration;

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

2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the Preventive Care Benefits described below, those tests or procedures will not be covered as Preventive Care benefits. Those tests and procedures that are **covered expenses** will be subject to the cost-sharing that applies to those specific services under this Plan.

Routine Physical Exams

Covered expenses include charges made by your **physician**, or if applicable, **primary care physician** (**PCP**), for routine physical exams, and are covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan)**.** This includes routine vision and hearing screenings given as part of the routine physical exam. A routine 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:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  Screening and counseling services, such as:
  Interpersonal and domestic violence;
  Sexually transmitted diseases; and

Human Immune Deficiency Virus (HIV) infections.
Screening for gestational diabetes.
High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.
- If your plan includes dependent coverage, for covered newborns, an initial **hospital** check up.

Routine Physical Exams through age 21 are subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered persons age 22 and older are subject to 1 visit per 12 or 24 consecutive months. Refer to your Schedule of Benefits for the time-period that applies.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- If applicable and currently excluded by your Booklet , services and supplies furnished by an **out-of-network provider**.

For details, contact your **physician,** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.

Preventive Care Immunizations

Covered expenses include charges made by your **physician** or a facility, covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan)**,** for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Limitations
Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your **physician**, or if applicable, **primary care physician** (**PCP**), obstetrician, or gynecologist for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive 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 is** covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan). The maximum for Well Woman Preventive Visits is one per plan/calendar year. Refer to your Schedule of Benefits for the time period that applies.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- If applicable and currently excluded by your Booklet , services and supplies furnished by an **out-of-network provider**.

Screening and Counseling Services

Covered expenses include charges made by your **physician**, or if applicable, **primary care physician** (**PCP**) in an individual or group setting for the following, and are covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan). In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Maximum screening and counseling services visits above are unlimited for those under age 22. For those age 22 or older, visits are limited to 26 visits per 12-month period, of which up to 10 visits may be used for healthy diet counseling.

Misuse of Alcohol and/or Drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Maximum screening and counseling services visits above are limited to 5 visits per 12-month period.

Use of Tobacco Products

Screening and counseling services to aid you to stop the use of tobacco products.

Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:

- cigarettes;
- cigars;
- smoking tobacco;
- snuff;
- smokeless tobacco; and
- candy-like products that contain tobacco.

Maximum screening and counseling services visits above limited to 8 visits per 12-month period.

Limitations:

Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- If applicable and currently excluded by your Booklet, services and supplies furnished by an **out-of-network provider**.

Routine Cancer Screenings

Covered expenses include, but are not limited to, the following charges covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan):

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- If applicable and currently excluded by your Booklet, services and supplies furnished by an **out-of-network provider**.

Important Notes:
For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician,** log onto the **Aetna** website www.aetna.com, or call the Member Services number on the back of your ID card.

Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a **physician's**, or if applicable, **primary care physician's** (**PCP**), obstetrician's, or gynecologist's office at 100% with no **deductible** or **copay** (in-network expenses only if network plan), but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related **physician** office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

This Plan covers prenatal care as described above even though pregnancy expenses may not be a **covered expense** under this Plan.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above); and
- If applicable and currently excluded by your Booklet, services and supplies furnished by an **out-of-network provider**.

Important Note:
Refer to the Pregnancy Expenses and Exclusions sections of your Booklet for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider, covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan) for the first 6 visits per 12 months. The applicable physician copayment percentage and deductible or copay applies thereafter. The "post partum period" means the one-year period directly following the child's date of birth. **Covered expenses** incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding **durable medical equipment** for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade), if requested within 60 days from the date of the birth of the child. A purchase will be covered once every three years following the date of the birth; or
  - A manual breast pump, if requested within 12 months from the date of the birth of the child. A purchase will be covered once every three years following the date of the birth.
- If an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

Limitations:

Unless specified above, not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- If applicable and currently excluded by your Booklet, services and supplies furnished by an **out-of-network provider**.

Important Notes:

As to plans that have a network of providers, if a breast pump service or supply that you need is covered under your plan but not available from a **network provider** in your area:

- if your plan requires **referrals**, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a **referral** that has been approved by **Aetna**, you will receive the network benefit level as shown below; or
- if your plan does not require **referrals**, contact Member Services by logging on to Aetna Navigator at www. aetna.com or at the toll-free number on your ID card for assistance.

Family Planning Services - Female Contraceptives

For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a **physician**, or if applicable, **primary care physician (PCP)**, obstetrician or gynecologist. Such counseling services are **covered expenses** when provided in either a group or individual setting, and are covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan). Contraceptive counseling visits are limited to a maximum of 2 visits per 12 months**.** Visits in excess of the Contraceptive Counseling Services Maximum are covered under the Physician Services office visit section of the Schedule of Benefits.

The following contraceptive methods are **covered expenses** under this Preventive Care benefit.

Voluntary Sterilization

Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan)**.**

Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives

Covered expenses include charges made by a **physician** or **pharmacy** for:

- Female contraceptives that are **generic prescription drugs**;
- Female contraceptive devices including the related services and supplies needed to administer the device;
- FDA-approved female generic emergency contraceptives;

and are covered at 100% with no **deductible** or **copay** (in-network expenses only if network plan) under this Preventive Care benefit.

When contraceptive methods are obtained at a **pharmacy**, **prescriptions** must be submitted to the pharmacist for processing.

Limitations:

Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
- Services which are for the treatment of an identified **illness** or **injury**;
- Services that are not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;

- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care;
- If applicable and currently excluded by your Booklet, services and supplies furnished by an **out-of-network provider**.

This amendment makes no other changes to the Group Contract or the Booklet.

Mark T. Bertolini
Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Preventive Care -Oral Contraceptives under Medical
Amendment: 1416
Issue Date: June 21, 2013