# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of Contents</td>
<td>2</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Important Contact Information</td>
<td>5</td>
</tr>
<tr>
<td>Eligibility</td>
<td>8</td>
</tr>
<tr>
<td>Associate Eligibility</td>
<td>8</td>
</tr>
<tr>
<td>Dependent Eligibility</td>
<td>9</td>
</tr>
<tr>
<td>Qualified Medical Child Support Orders (QMCSO)</td>
<td>11</td>
</tr>
<tr>
<td>Types of Coverage</td>
<td>12</td>
</tr>
<tr>
<td>Enrollment</td>
<td>13</td>
</tr>
<tr>
<td>New Hire, Rehire and Reinstatement</td>
<td>13</td>
</tr>
<tr>
<td>Associate Status Change</td>
<td>13</td>
</tr>
<tr>
<td>Annual Open Enrollment</td>
<td>13</td>
</tr>
<tr>
<td>Change in Status Events</td>
<td>14</td>
</tr>
<tr>
<td>Contributions</td>
<td>16</td>
</tr>
<tr>
<td>Pre-tax Contributions</td>
<td>16</td>
</tr>
<tr>
<td>Post-tax Contributions</td>
<td>16</td>
</tr>
<tr>
<td>Failure to Make Contributions (or Insufficient Funds)</td>
<td>16</td>
</tr>
<tr>
<td>Commitment to Health Program</td>
<td>17</td>
</tr>
<tr>
<td>Continuation of Coverage during a Leave of Absence</td>
<td>18</td>
</tr>
<tr>
<td>Medical Plan Highlights</td>
<td>19</td>
</tr>
<tr>
<td>Prescription Drug Program Highlights</td>
<td>27</td>
</tr>
<tr>
<td>Medical Plan Provisions</td>
<td>28</td>
</tr>
<tr>
<td>Plan Year Deductible</td>
<td>28</td>
</tr>
<tr>
<td>Copayments</td>
<td>28</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>29</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>29</td>
</tr>
<tr>
<td>Recognized (or Reasonable &amp; Customary) Charges</td>
<td>29</td>
</tr>
<tr>
<td>Pre-Treatment Estimates</td>
<td>29</td>
</tr>
<tr>
<td>Precertification of Services – Precertification Penalty</td>
<td>29</td>
</tr>
<tr>
<td>Aetna HealthFund Account (Select 70 Only)</td>
<td>30</td>
</tr>
<tr>
<td>Health Savings Account (Core 60 Only)</td>
<td>31</td>
</tr>
<tr>
<td>Choosing the Right Place and Provider for Care</td>
<td>32</td>
</tr>
<tr>
<td>Aetna Programs and Resources</td>
<td>36</td>
</tr>
<tr>
<td>Aetna Navigator - A Secure Member Website</td>
<td>36</td>
</tr>
<tr>
<td>Health Concierge</td>
<td>36</td>
</tr>
<tr>
<td>Health Care Advocate</td>
<td>36</td>
</tr>
<tr>
<td>Autism Advocate Program</td>
<td>36</td>
</tr>
<tr>
<td>Aetna In Touch Care</td>
<td>37</td>
</tr>
<tr>
<td>Beginning Right Maternity Program</td>
<td>37</td>
</tr>
<tr>
<td>NeoCare Solutions</td>
<td>37</td>
</tr>
<tr>
<td>Aetna Discount Programs</td>
<td>38</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>39</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td>43</td>
</tr>
<tr>
<td>Prescription Drug Program</td>
<td>47</td>
</tr>
<tr>
<td>Covered Services</td>
<td>51</td>
</tr>
<tr>
<td>Women’s Health and Cancer Rights Act</td>
<td>58</td>
</tr>
<tr>
<td>Women's Health and Cancer Rights Act</td>
<td>58</td>
</tr>
<tr>
<td>Aetna Discount Programs</td>
<td>38</td>
</tr>
</tbody>
</table>

Health Care Plan Summary Plan Description — Effective March 1, 2017
Table of Contents (cont.)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions</td>
<td>59</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>62</td>
</tr>
<tr>
<td>The Plan’s Right to Recover Overpayment</td>
<td>64</td>
</tr>
<tr>
<td>Right to Audit</td>
<td>65</td>
</tr>
<tr>
<td>Subrogation/Reimbursement</td>
<td>66</td>
</tr>
<tr>
<td>Benefits May Not Be Assigned</td>
<td>68</td>
</tr>
<tr>
<td>Claims Information</td>
<td>69</td>
</tr>
<tr>
<td>Medical Claims with Aetna</td>
<td>69</td>
</tr>
<tr>
<td>Prescription Drug Claims with CVS Caremark</td>
<td>72</td>
</tr>
<tr>
<td>How to Appeal a Denied Claim for Benefits</td>
<td>72</td>
</tr>
<tr>
<td>Deadline to Bring Legal Action</td>
<td>77</td>
</tr>
<tr>
<td>Appealing an Enrollment or Eligibility Status Decision</td>
<td>77</td>
</tr>
<tr>
<td>Forum for Legal Action</td>
<td>77</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>78</td>
</tr>
<tr>
<td>The Associate’s Coverage</td>
<td>78</td>
</tr>
<tr>
<td>The Dependents’ Coverage</td>
<td>78</td>
</tr>
<tr>
<td>Optional Continuation of Coverage (COBRA)</td>
<td>79</td>
</tr>
<tr>
<td>Important Notices</td>
<td>82</td>
</tr>
<tr>
<td>Comprehensive Notice of Privacy Practices - HIPAA</td>
<td>82</td>
</tr>
<tr>
<td>Important Notice from CarMax about Your Prescription Drug Coverage and Medicare</td>
<td>86</td>
</tr>
<tr>
<td>Premium Assistance under Medicaid and the State Children’s Health Insurance Program (SCHIP) Notice</td>
<td>88</td>
</tr>
<tr>
<td>Glossary</td>
<td>89</td>
</tr>
<tr>
<td>General Information about This Plan</td>
<td>93</td>
</tr>
<tr>
<td>Participant’s Rights under ERISA</td>
<td>95</td>
</tr>
</tbody>
</table>

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please reference the section entitled “Important Notice from CarMax about Your Prescription Drug Coverage and Medicare” for more details.
Introduction

CarMax offers eligible Associates the opportunity to participate in this Health Care Plan, which is referred to in this document as the “Plan.” The Plan is a component program under the CarMax, Inc. Master Welfare Plan (“Master Welfare Plan”) and is an important part of CarMax’s total benefits program.

This document is designed to be an easy-to-read summary of the Plan. You are encouraged to read this document and share it with your family members. Some terms in this document have a special meaning and begin with a capital letter. These terms are defined throughout this document or in the Glossary.

This Document and Other Plan Documents

This document is the Summary Plan Description (“SPD”) and, along with the Commitment to Health Policy and any subsequent Summary of Material Modifications, constitutes the Plan’s full SPD. It summarizes the Plan’s terms as of March 1, 2017. In addition to this SPD, the Plan is subject to the terms of the Master Welfare Plan. The Master Welfare Plan document, together with this SPD, constitutes the written instrument under which the Plan is established and maintained. An amendment to any one of these documents is a Plan amendment.

If the terms of this SPD conflict with the terms of the Master Welfare Plan, the terms of the Master Welfare Plan will prevail. You may obtain a copy of the Master Welfare Plan at no charge by sending a written request to the Plan Administrator.

Summaries of Benefits & Coverage

Choosing your health coverage is an important decision. To help you make an informed choice, the Plan provides a Summary of Benefits and Coverage (“SBC”) which summarizes important information about health coverage options in a standard format to help you compare your options.

SBCs are available on the CarMax Benefits website at benefits.carmax.com. A paper copy is also available, free of charge, upon request by calling the MYKMXHR Service Center at (888) 695-6947.

A Partnership in Health Care

The Plan is a partnership in health care in which the Associate and the Company share the costs. This Plan is self-insured, which means costs are based on the actual medical expenses of covered Associates and their families. Because the cost of coverage – to both the Associate and the Company – is directly related to claims expenses, it is important to be prudent consumers of health care services. Maintaining a healthy lifestyle, avoiding unnecessary treatment, and being informed about the services received will help control the costs of the Plan.

The Plan consists of three Medical Plan options and the corresponding Prescription Drug Program.

We have three Medical Plan options, each administered by Aetna: Premium 80, Select 70 and Core 60. Each option covers the same services, but at different costs to you, both from your paycheck and when you use covered services. Each option encourages the use of Network Providers who charge agreed-upon rates. You receive higher benefit levels and have lower out-of-pocket costs when you use Network Providers.

Our Prescription Drug Program is administered by CVS Caremark. This Program provides access to an extensive network of pharmacies across the country from which you can purchase Medically Necessary prescription drugs at discounted prices. Information about this Program is located on the CarMax Benefits website, which is accessible from the CarMax World or at benefits.carmax.com from any computer with internet access.

The Company reserves the right to revise or terminate the Plan, in whole or in part, at any time and without prior notice to you. The Company also may revise the Plan as necessary to comply with law.

CarMax, the Plan Administrator and third parties such as Aetna and CVS Caremark are not health care providers and are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive.
# Important Contact Information

## Medical Plan Contact Information

<table>
<thead>
<tr>
<th>Types of Questions</th>
<th>Who to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Covered Medical Services</td>
<td>Aetna</td>
</tr>
<tr>
<td>• Help finding a Network Provider</td>
<td>(866) 498-5004</td>
</tr>
<tr>
<td>• Claims status Information</td>
<td>8:00 a.m. to 6:00 p.m., for all U.S. time zones</td>
</tr>
<tr>
<td>• If you need new Aetna (Medical) ID cards</td>
<td>Monday through Friday</td>
</tr>
<tr>
<td></td>
<td>Online: <a href="http://aetna.com">aetna.com</a></td>
</tr>
</tbody>
</table>

**Or to reach:**

- Health Concierge
- Health Care Advocate
- Autism Support Advocate
- Medical Management*
- In Touch Care
- Beginning Right Program
- Healthy Lifestyle Coach

*Precertification/Pre-treatment estimates - Medical Management*

- Network providers will seek precertification for In-Network Services; however, you are responsible for obtaining precertification for Non-Network Services.
- Prior to receiving any health care services from a Non-Network provider, you should call Aetna to confirm whether precertification is required.
- See the “Medical Plan Highlights” and “Covered Services” sections for information on precertification requirements.
- You may contact Aetna’s Medical Management group for any questions on pre-treatment estimates

## For Aetna Network Provider Information

*NOTE: the same Network of Providers applies to all three Plan options*

- Online: [aetna.com](http://aetna.com) - Find a Doctor
- Select: Aetna Choice POS II (Open Access) Network
<table>
<thead>
<tr>
<th>Types of Questions</th>
<th>Who to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>If Non-Network, Precertification requirements apply, refer to the “Managed Mental Health &amp; Substance Abuse Program.</td>
<td>Aetna (866) 498-5004</td>
</tr>
<tr>
<td>Aetna Healthy Lifestyle Coaching Program</td>
<td>Aetna (866) 498-5004 (Main) or (866) 213-0153 (Direct)</td>
</tr>
<tr>
<td>24/7 Aetna Nurse Line (Informed Health Line)</td>
<td>Aetna (866) 498-5004 (Main) or (800) 556-1555 (Direct)</td>
</tr>
<tr>
<td>You can talk with someone 24/7 if you have questions about healthcare decisions in a non-emergency situation. You have telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses can offer support for your healthcare decision-making and also help you improve your relationship with your doctor through information and support.</td>
<td></td>
</tr>
<tr>
<td>Teladoc</td>
<td>(855) 835-2362 (855-TELADOC) teladoc.com/aetna</td>
</tr>
<tr>
<td>To schedule a telephonic or video consultation</td>
<td></td>
</tr>
<tr>
<td><strong>COBRA Administrator</strong> (When coverage ends)</td>
<td>COBRA Administration Services (888) 695-6947 Online: <a href="https://cobra.onesourceadministrativesolutions.com">https://cobra.onesourceadministrativesolutions.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drug Program Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of Questions</td>
</tr>
<tr>
<td>Prescription Drug Program:</td>
</tr>
<tr>
<td>• Covered Prescriptions</td>
</tr>
<tr>
<td>• Formulary information</td>
</tr>
<tr>
<td>• Finding an In-Network pharmacy</td>
</tr>
<tr>
<td>• If you need new Pharmacy ID cards</td>
</tr>
</tbody>
</table>
### Other Contact Information

<table>
<thead>
<tr>
<th>Types of Questions</th>
<th>Who to Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For information on:</strong></td>
<td><strong>MYKMXHR Service Center</strong></td>
</tr>
<tr>
<td>• Eligibility to participate</td>
<td>(888) 695-6947</td>
</tr>
<tr>
<td>• Enrollment</td>
<td>8:00 a.m. to 8:00 p.m. ET</td>
</tr>
<tr>
<td>• Payroll Deductions</td>
<td>Monday through Friday</td>
</tr>
<tr>
<td>• Change in Status or Life Events (e.g., marriage, divorce, birth of a child, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>CarMax Benefits Website</strong></td>
<td><strong>CarMax World – Benefits</strong></td>
</tr>
<tr>
<td>• Plan Information</td>
<td><a href="http://benefits.carmax.com">benefits.carmax.com</a></td>
</tr>
<tr>
<td>• Contact Information</td>
<td></td>
</tr>
<tr>
<td>• Commitment to Health Information</td>
<td></td>
</tr>
</tbody>
</table>
Eligibility

This section describes who is eligible for coverage and when they become eligible. Please refer to the Enrollment Section below for information about how to enroll and the resulting effective date of coverage.

Associate Eligibility

If you are a “Regular Full-time Associate,” meaning that you are regularly scheduled to work at least 30 hours per week, you are eligible to join the Plan effective the first of the month following one calendar month of continuous employment (this period is called the “Waiting Period”).

- For example, if you were hired on May 2, you would be eligible to join the Plan on July 1 (the Waiting Period would be May 2 to June 30).

If you are a non-employee member of the CarMax Board of Directors, and your service on the Board of Directors began on or before June 23, 2014, you are eligible to join the Plan effective the first of the month following your appointment or election to the Board of Directors, so long as you are not otherwise covered by a group health plan sponsored by another employer.

An Associate cannot receive coverage under this Plan as both an Associate and a dependent, or as a dependent of more than one Associate.

If you are a “Part-time Associate,” as designated by your employment status, hired before June 1, 1993, you are eligible for “Associate Only” coverage under this Plan.

Part-time Associates hired after June 1, 1993, and Temporary Associates are not eligible for coverage under this Plan.

Status Change

If your status changes to Regular Full-time, you are eligible to join or re-enter the Plan as follows:

- If you were a Part-time Associate (whether Temporary or Regular), with less than one month of service, you will be eligible to join the Plan as of the first of the month following one calendar month of continuous employment.
  - For example, if you were hired as a Part-time Associate on March 2 and had a status change to Full-time on March 25, you would be eligible to join the Plan effective May 1.

- If you were a Part-time Associate with more than one month of service, you will be eligible to join the Plan as of the first of the month after the status change.
  - For example, if you were hired as a Part-time Associate on October 2 and had a status change to Full-time on March 15, you would be eligible to join the Plan effective April 1.

- If you were a Regular Full-time Associate, your status changed to Part-time or Temporary, and you return to Regular Full-time status, you are required to enroll in the Plan should you wish to be covered. If you were previously covered by the Plan, the coverage you had will not be reinstated automatically. You will be eligible to join the Plan effective the first of the month following the status change to Regular Full-time.
  - For example, if your status changed from Regular Full-time to Part-time on May 11 and back to Regular Full-time on September 25, you would be eligible to join the Plan effective the first of the month (October 1) after the status change.

If your status changes from Regular Full-Time to Part-Time, your coverage will terminate at the end of the month of your status change.
Rehire/Reinstatement

If you terminate employment and are later rehired or reinstated as a Regular Full-Time Associate within 30 days of termination, you will be eligible to resume your prior election effective the first of the month following your date of rehire or reinstatement.

If you terminate employment and are later rehired or reinstated as a Regular Full-Time Associate more than 30 days after your termination, you will be eligible to join the Plan on the first of the month following one calendar month of continuous employment from your date of rehire or reinstatement.

Any prior coverage will not be reinstated automatically; rather, you must re-enroll in the Plan in accordance with the provisions described in the Enrollment section below.

If you are rehired or reinstated in the same Plan Year, you will receive credit for expenses applied toward Deductibles and Out-of-Pocket Maximums while previously covered during that Plan Year.

Dependent Eligibility

You will be required to provide a Certification of Dependent Eligibility and documentation verifying the eligibility of any dependent that you elect to cover under this Plan. You will receive a letter from the MYKMXHR Service Center shortly after your enrollment with instructions on how to complete the verification process. Failure to submit the required documentation, whether due to a failure to respond to the request or a failure to submit acceptable documentation, will result in coverage for the unverified dependent being rejected, terminated or rescinded, as permitted by law.

If your unverified dependent’s coverage is terminated, you may appeal for such coverage to be reinstated, provided that you submit the required documentation by the appeal deadline. If your dependent’s coverage is reinstated effective as of the date coverage is lost, you are responsible for paying any contributions applicable to the reinstated coverage and you agree that such contributions will be held in arrears and collected from your future paycheck(s).

Please refer to the following documents, which are available at benefits.carmax.com for more information about verification requirements and how to appeal a verification failure:

- Dependent Eligibility Verification FAQs;
- Dependent Eligibility Verification (Proof) Document List;
- Certification of Dependent Eligibility for Covered Dependents; and
- Dependent Eligibility Appeal Form.

If you have any questions regarding dependent eligibility, please contact the MYKMXHR Service Center at (888) 695-6947.

Residency of Dependent

Dependents (whether Spouse, Domestic Partner, or Child) are eligible for coverage under the Plan only if they reside in the United States or are participating in post-secondary education full-time outside of the United States.

Spouse

The person to whom you are legally married under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, but excluding an individual who is legally separated from you.

Domestic Partner

Your Domestic Partner will be eligible for coverage provided he or she meets the requirements outlined below and you complete a Certification of Domestic Partnership when you enroll.

A “Domestic Partner” is an individual of either gender who is not your Spouse, but who meets the criteria below. For the Domestic Partner to be covered under this Plan, both the Associate and the Domestic Partner must meet all of the following conditions:
• Not be married to anyone else nor be the Domestic Partner of anyone else;
• Have been in an exclusive and committed relationship for one year or more;
• Not be related by blood closer than would bar marriage under applicable law;
• Live together in the same permanent residence and intend to do so indefinitely;
• Be jointly responsible for each other’s welfare and be financially interdependent, or the Domestic Partner is chiefly dependent upon you, the Associate, for care and financial assistance; and
• Be at least 18 years old and mentally competent to enter into a legal contract.

In the event that the Associate and his or her Domestic Partner takes all steps necessary to be registered as a domestic partner or entered into a civil union under state law, the Plan will recognize the Associate’s Domestic Partner even if the above conditions are not all met.

A Certification of Domestic Partnership is your statement certifying that you have a Domestic Partner and that both of you meet the above requirements. When you elect coverage for your Domestic Partner, you must complete a Certification of Dependent Eligibility in which you certify that you and your Domestic Partner meet these requirements.

Please refer to the Domestic Partner Benefits Policy on the CarMax Benefits website for additional information.

Children

In order to be eligible for coverage under the Plan your child must be under age 26 and be one of the following:

• Your biological child;
• Your adopted child (or a child placed for adoption);
• Your stepchild;
• Your foster child;
• Any other child for whom you have legal guardianship or who, by court order, is a dependent for purposes of providing health care coverage and who is your tax dependent for federal income tax purposes; or
• The biological or adopted child(ren) of your Domestic Partner, provided you enroll your Domestic Partner for coverage and the child(ren) are your tax dependent(s) for federal income tax purposes. (Please note that children who are the tax dependents of your domestic partner cannot qualify as your tax dependents.)

Coverage for children will automatically cease at the end of the calendar month in which they reach age 26 and, if appropriate, your benefit (payroll) deductions may be impacted.

Handicapped Dependent Children

Provided your child meets the eligibility requirements described above, coverage for your fully handicapped dependent child who is covered prior to reaching the date they reach the maximum age for a dependent child may be continued beyond that date provided:

• He or she is not able to earn his or her own living because of a mental or physical handicap that started prior to the date he or she reached age 26;
• He or she depends chiefly on you for support and maintenance; and
• He or she is related to or resides with you and is your tax dependent.

Proof that your child is fully handicapped must be submitted to the MYKMXHR Service Center no later than 31 days after the date your child reaches age 26.
Qualified Medical Child Support Orders (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. The order must meet certain requirements to be qualified as a QMCSO. The Plan Administrator will determine whether an order meets these requirements.

The Plan will provide coverage for a child who is covered under a QMCSO if the child meets the Plan's definition of an eligible dependent.

Once an order is determined to be a QMCSO, coverage for the dependent will be effective the first of the following month unless the order requires a later start date. You may request a copy of the Plan’s procedures for QMCSO determinations, free of charge, by contacting the MYKMXHR Service Center at (888) 695-6947 or online at benefits.carmax.com.
Types of Coverage

The type of coverage you select depends on the eligible individuals to be covered:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Only</td>
<td>Covers the Associate Only</td>
</tr>
<tr>
<td>Associate and Child</td>
<td>Covers the Associate and one eligible child only</td>
</tr>
<tr>
<td>Associate plus Children</td>
<td>Covers the Associate and two or more eligible children</td>
</tr>
<tr>
<td>Associate and Spouse</td>
<td>Covers the Associate and Spouse only</td>
</tr>
<tr>
<td>Associate and Domestic Partner</td>
<td>Covers the Associate and Domestic Partner only</td>
</tr>
<tr>
<td>Family with Spouse</td>
<td>Covers the Associate, a Spouse, and one or more eligible children</td>
</tr>
<tr>
<td>Family with Domestic Partner</td>
<td>Covers the Associate, a Domestic Partner, and one or more eligible children</td>
</tr>
</tbody>
</table>
Enrollment

This section describes how to enroll in the Plan once you are eligible. This section also describes when you may enroll in the Plan (your “Enrollment Period”). All enrollments must be completed online at www.mykmxhr.com. Paper enrollment forms will not be accepted. If you have questions or need assistance, please contact the MYKMXHR Service Center at (888) 695-6947.

The “Effective Date of Coverage” is the date as of which you are eligible to have coverage under the Plan become effective (provided you enroll within your Enrollment Period).

New Hire, Rehire and Reinstatement

If you are a newly hired, rehired or reinstated Associate, you have the option of enrolling yourself and your eligible dependents in the Plan or waiving coverage when you are first eligible.

Newly hired, rehired and reinstated Associates are eligible for coverage effective the first day of the month following one calendar month after your date of hire, rehire or reinstatement provided you make your election within the required Enrollment Period. The Enrollment Period is as follows: You must enroll in coverage by the later of (a) your Effective Date of Coverage, or (b) 30 days from your date of hire, rehire, or reinstatement.

Late Enrollment Provisions: If you are a Regular Full-time Associate and do not elect coverage within your Enrollment Period, you may enroll in coverage, which will be effective the first day of the month following your date of election, provided you enroll within the same Plan Year as your date of hire, rehire, or reinstatement.

Associate Status Change

From Part-time to Full-time: If you change status from Part-time to Full-time, you become eligible to enroll in the Plan. If you have been employed for more than one month when your status change occurs, you have the longer of (a) 30 days from the date of your status change or (b) the first of the month following one calendar month after your status change to make your election. The Effective Date of your Coverage is the first day of the month following the date you elect coverage.

- For example: If you transfer from Part-Time to Full-Time on May 15th and make your election to enroll in coverage on May 31st, your coverage will be effective June 1. If, however, you do not make your election until June 4th, your coverage will be effective July 1.

From Full-time to Part-time: If you change status from Full-time to Part-time, you are not eligible to participate in the Plan (unless you were hired prior to June 1, 1993). Coverage will terminate automatically at the end of the month of your status change.

Annual Open Enrollment

An Open Enrollment period is held each year in January for coverage under this Plan. During Open Enrollment, you may add, drop, or change your coverage, including changing from one Plan option to another. Your election will be effective March 1. Unless you are advised otherwise, if you do not change your coverage election during Open Enrollment, your previous election will continue.

Please consider your annual elections carefully. Once those elections take effect, you will not be able to change those elections unless you experience a change in status event as described below.
Change in Status Events

When you experience a “Change in Status” event, as defined below, you are permitted to add, drop, or change coverage (including changing from one Plan option to another) for yourself and your dependents without having to wait until the next annual Open Enrollment. Your election must be “consistent” with the Change in Status Event (i.e., be on account of and correspond with the event and impact eligibility).

“Change in Status Events” include the following:

- Marriage, legal separation or divorce
- Death of your Spouse or dependent
- Gaining or losing a Domestic Partner
- Birth, adoption of a child or placement for adoption (please see note below)
- Your Spouse or Domestic Partner ending or starting employment (or commences or returns from an unpaid leave of absence) and that circumstance affects coverage eligibility
- You or your Spouse changing from full-time to part-time employment status, or vice versa, when the change affects coverage eligibility
- A significant change in the cost of your coverage or a significant change in your coverage
- You enroll in coverage through your Spouse or Domestic Partner’s employer during their annual open enrollment
- Loss of eligibility (for you or your dependents) for another group health plan or a state/federal insurance program such as Medicare, Medicaid or the Children’s Health Insurance Program (CHIP)
- Gain or loss of coverage through the Health Insurance Marketplace
- Change in a dependent child’s status, such as the loss of eligibility for your dependent because of exceeding the age eligibility requirements
- A change in the place of residence for you, your Spouse or your dependent child

For events that involve adding coverage, the Effective Date of Coverage will be the first day of the month following the date you complete your election.

An exception to this rule applies to birth, adoption, or placement for adoption events – In these cases you must enroll within 30 days from the date of birth, adoption, or placement for adoption in order to have the Effective Date of Coverage be as of the child’s date of birth, adoption or placement for adoption. If you do not enroll the child within 30 days from the date of birth, adoption, or placement for adoption, the Effective Date of Coverage will be the first of the month following the date you complete your election, unless you fall within the special exception for family coverage discussed below under “Late Enrollment.”

You will be required to provide documentation verifying the Change in Status Event from the above list and the eligibility of any dependents you may add to your coverage. You will be contacted by the MYKMXHR Service Center and provided a list of acceptable documents. Failure to submit the required documentation will result in the requested change in coverage being rejected, terminated or rescinded, as permitted by law.

For events that involve dropping coverage, the effective date of the change will be the last day of the month following the date you complete your election. An exception to this rule applies to the death of a covered individual, in which case coverage will cease as of the date of death.

Note: If you fail to drop coverage for a dependent who has become ineligible during the required Election (Enrollment) Period, deductions withheld for such coverage will only be refunded if you provide notification within the same Plan Year. You will also be responsible, to the fullest extent allowed by law, for any claims paid from the Plan for the ineligible dependent.
State Children’s Health Insurance Program (SCHIP) Special Enrollment Provisions

An Associate, Spouse and/or Dependent who is otherwise eligible for coverage under the Plan will have a special enrollment right under this Plan upon either (1) the termination of Medicaid or SCHIP coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance under a Medicaid or SCHIP program. In order to be entitled to the special enrollment right, the Associate must request Health Care coverage within (i) 60 days of the termination of Medicaid or SCHIP coverage, (ii) 60 days of the date the Associate, Spouse or Dependent is determined to be eligible for assistance, or (iii) otherwise satisfy the “Late Enrollment” provisions as described below.

HIPAA Special Enrollment Statement

If you decline enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, and if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage), then you may be able to enroll yourself and your Dependents in this Plan or change from one Plan option to another. However, you must enroll within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage), or within the “Late Enrollment” period discussed below.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in this Plan or change from one Plan option to another. However, you must enroll within 30 days after the marriage, birth, adoption, or placement for adoption, or within the “Late Enrollment” period discussed below.

To request special enrollment or obtain more information, contact the MYKMXHR Service Center at (888) 695-6947.

Late Enrollment

Late Enrollment Provisions for Birth, Adoption, or Placement for Adoption: If you fail to add a new dependent child within 30 days of the Change in Status Event, you can add that child effective the first of the month following the date reported, if the change is reported within the same Plan Year as the Change in Status Event, or, where the Change in Status Event occurs in the last month of the Plan Year, if the change is reported within 60 days of the Change in Status Event.

A special exception to this rule exists if you already have family coverage and have another child through birth, adoption, or placement for adoption. In this case, coverage for the child will be effective on the date of the Change in Status Event provided the change is reported within the same Plan Year, or, where the Change in Status Event occurs in the last month of the Plan Year, if the change is reported within 120 days of the Change in Status Event.

Late Enrollment Provisions for Events Other Than for Birth, Adoption, or Placement for Adoption: If you experience a Change in Status Event other than birth, adoption, or placement for adoption and make your election within the same Plan Year as the Change in Status Event, or, where the Change in Status Event occurs in the last month of the Plan Year and you make your election within 60 days, the change consistent with the Change in Status Event can be made effective the first of the month following enrollment.
Contributions

The cost of the Plan is paid by contributions from the Company and participating Associates. Costs are based on the actual claims and expenses experienced by the Plan. Associate contribution amounts are subject to change at any time. You will be advised if an increase or decrease is necessary. Associate contributions are deducted from your pay and collected each pay period, unless you are on an approved leave of absence and being billed through the Direct Bill program (please see the section titled “Continuation of Coverage during a Leave of Absence”).

Pre-tax Contributions

Your Plan contributions are deducted from your pay before taxes are calculated. This means that the portion of your pay contributed to the Plan is not subject to federal or state income or Social Security and Medicare taxes. You are permitted to make these pre-tax contributions because the Plan is an eligible benefit program under the CarMax, Inc. Pre-tax Flexible Benefits Plan, which is a "cafeteria plan" within the meaning of Internal Revenue Code section 125. However, under Internal Revenue Code rules, you cannot change the coverage you have elected after the annual Open Enrollment period for the following Plan Year except in limited situations, such as a change in your family status. These situations are described in detail in the “Enrollment” section of this document.

Contact the MYKMXHR Service Center at (888) 695-6947 immediately if you have any questions about your paycheck deductions.

Effect of Pre-tax Contributions on Other Benefits

When Social Security taxes are reduced, future benefits from Social Security will be slightly lower. In general, however, the reduction in benefits is very small and is offset by the increase in take-home pay.

Post-tax Contributions

If you are a Part-time Associate who was hired before June 1, 1993, contributions to the Plan will be made on a post-tax basis. In such cases, Associate contributions are deducted from pay after taxes are calculated.

If you elect to cover your Domestic Partner under the Plan, the portion of the cost attributable to coverage for your Domestic Partner will be deducted on a post-tax basis. Under the Internal Revenue Code, the fair market value of coverage for your Domestic Partner (less any amount you pay after tax) must be added to your income and subject to ordinary federal, FICA, state, local and any other applicable payroll taxes. These tax rules may differ if the Domestic Partner is also your tax dependent. Please refer to the Domestic Partner Benefits Policy on the CarMax Benefits website for more detailed information.

Failure to Make Contributions (or Insufficient Funds)

If you are not receiving pay or if your pay for a given pay period is insufficient to cover the full cost of your contributions, you remain responsible for payment of those contributions. In such case, it is your responsibility to contact the MYKMXHR Service Center at (888) 695-6947 to discuss making your payments. Failure to remit contributions may result in your coverage being terminated as of the last day of the month for which contributions were paid. Please see the section titled “When Coverage Ends.”

In addition, any missed contributions will be accrued in arrears and deducted from the next available paycheck(s) by doubling your paycheck deduction amount until your arrears are paid in full. By accepting benefits from the Plan, you are agreeing to this arrangement.

For information about coverage and contributions during an approved leave of absence, please see the section titled “Continuation of Coverage during a Leave of Absence.”
Commitment to Health Program

CarMax is committed to helping you achieve your best health. For this reason, we ask all Associates who enroll in the Plan and their covered Spouse or Domestic Partner to participate in our voluntary Commitment to Health Program.

The Commitment to Health Program asks you and your covered Spouse or Domestic Partner to complete certain actions during the Plan Year and offers each of you a credit toward your Plan contributions for doing so.

The terms and conditions of the Program are set forth in the Commitment to Health Policy, which is available at benefits.carmax.com. The Commitment to Health Policy is incorporated into this Summary Plan Description.
Continuation of Coverage during a Leave of Absence

CarMax realizes that Associates may be faced with conditions beyond their control, such as personal or family emergencies, that may require a leave of absence. In accordance with the CarMax leave policies, coverage under this Plan may remain in effect for up to six months during an approved leave provided you make any required contributions.

You are responsible for paying the required contributions for coverage during the period of leave.

- If you receive paychecks during any approved leave of absence, contributions will be made through payroll deductions.
- If you are not receiving paychecks or your paychecks are insufficient to cover the cost of contributions, you remain responsible for payment of the contributions.
- Generally, you will receive a monthly invoice while on an approved leave for the cost of coverage. If you do not receive a monthly invoice and contributions are not being withheld via a paycheck, it is your responsibility to contact the Direct Bill Services at (888) 695-6947.
- If your contributions are not paid, coverage may be terminated as of the last day of the month for which contributions were paid.
- In addition, if any unpaid contributions remain outstanding, including contributions that were not collected due to insufficient funds prior to you receiving Direct Bill invoices, those contributions will be withheld from subsequent paychecks when you return to work by doubling your paycheck deduction amount until your arrears are paid in full, as permitted by law. By accepting benefits from the Plan, you are agreeing to this arrangement.

If you are on an approved leave, you may enroll or make changes during the annual Open Enrollment or if you experience a Change in Status Event, the same as any similarly situated active Associate.

**Special Note for Military Leaves:** If you are on a Military Leave, you may be eligible for medical coverage under the Military’s Health Plans. If, as a result of your participation in such a plan, you choose to terminate coverage under the CarMax Plan, you must waive coverage online at [www.mykmxhr.com](http://www.mykmxhr.com) or call the MYKMXHR Service Center at (888) 695-6947 in order for the change to take effect. You must make your election to drop coverage within the same Plan Year in which your leave of absence began. Your change in coverage will be effective the first of the month following your election.
Medical Plan Highlights

Each Plan option – Premium 80, Select 70, and Core 60 – covers the same services, but at different costs to you. Each Plan option has unique Deductibles, Out-of-Pocket Maximums, Copayments, and Coinsurance for covered services. The paycheck deductions for each Plan option are also different.

The following chart outlines the major provisions of each Plan option. Refer to the Covered Services, Prescription Drug Program and the Managed Mental Health and Substance Abuse Program sections of this document for specific information.

The Plan provisions described below list the major types of expenses covered by the Plan. The Plan does not cover all health care expenses and includes exclusions and limitations. For further details, please review the Covered Services and Exclusions section of this document or contact Aetna (see “Contact Information”).

### Deductible & Out-of-Pocket Maximums: In-Network Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80</th>
<th>Select 70</th>
<th>Core 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible (Includes both Medical and prescription charges)</td>
<td>$600/Individual</td>
<td>$1,700/Individual $3,400/Two-person(1) $5,100/Family(1)(2)</td>
<td>$2,000/Individual $4,000/Two-person $6,000/Family</td>
</tr>
<tr>
<td>CarMax’s Contribution to Your Account</td>
<td>n/a</td>
<td>Health Reimbursement Account $200/Individual $400/Two-person $600/Family</td>
<td>Health Savings Account $200/Individual $400/Two-person $600/Family</td>
</tr>
<tr>
<td>Plan Year Out-of-Pocket Maximum (Includes both Medical and prescription charges)</td>
<td>$ 6,550/Individual $ 13,100/Two-person $13,100/Family</td>
<td>$ 6,550/Individual $13,100/Two-person $13,100/Family</td>
<td>$ 6,650/Individual $13,100/Two-person $13,100/Family</td>
</tr>
</tbody>
</table>

(1) For this coverage tier, the deductible shown is the aggregate of individual deductibles that must be satisfied separately as follows:
- For two-person coverage, the Individual Deductible shown applies to each member; and
- For family coverage, the Individual Deductible shown applies to each of: (i) the associate; (ii) the spouse/domestic partner; and (iii) all other covered dependents (combined).

For purposes of clarification, one member (or, in the case of family coverage, two members) cannot satisfy the total deductible for all members.

(2) Note that deductible amounts for family coverage in the Select 70 option may not meet the minimum creditable coverage requirements for Massachusetts residents. Contact the MYKMXHR Service Center at (888) 695-6947 for more information.

### Deductible & Out-of-Pocket Maximums: Non-Network Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80</th>
<th>Select 70</th>
<th>Core 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible</td>
<td>$1,800/Individual $3,600/Two-person(1) $5,400/Family(1)</td>
<td>$ 4,250/Individual $ 8,500/Two-person(1) $12,750/Family(1)</td>
<td>$ 5,000/Individual $10,000/Two-person $15,000/Family</td>
</tr>
<tr>
<td>Plan Year Out-of-Pocket Maximum</td>
<td>$13,100/Individual $26,200/Two-person $26,200/Family</td>
<td>$13,100/Individual $26,200/Two-person $26,200/Family</td>
<td>$13,100/Individual $26,200/Two-person $26,200/Family</td>
</tr>
</tbody>
</table>
For this coverage tier, the deductible shown is the aggregate of individual deductibles that must be satisfied separately as follows:

- For two-person coverage, the Individual Deductible shown applies to each member; and
- For family coverage, the Individual Deductible shown applies to each of: (i) the associate; (ii) the spouse/domestic partner; and (iii) all other covered dependents (combined).

For purposes of clarification, one member (or, in the case of family coverage, two members) cannot satisfy the total deductible for all members.

Network and Non-Network Plan Year Deductibles and Out-of-Pocket Maximums accumulate separately. Covered Expenses applied toward the Network Deductibles and Out-of-Pocket Maximums do not satisfy Non-Network Deductibles and Out-of-Pocket Maximums, and vice versa.

All In-Network coverage amounts stated as 80%, 70%, or 60% are applied after the applicable In-Network Deductible is satisfied. All Non-Network coverage amounts stated as 50% are applied after the applicable Non-Network Deductible is satisfied. Services covered at 100% are not subject to the Plan’s Deductible unless noted otherwise.

**Office Visits: In-Network**

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician (PCP)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes Family or General Practitioners, Internists, Pediatricians, and OB/GYNs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Preventive Care Visit</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>- Non-Preventive Care Visit</td>
<td>100% coverage after $20 member Copay</td>
<td>100% coverage after $30 member Copay</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Teladoc Consultation</strong></td>
<td>100% coverage after $10 member Copay</td>
<td>100% coverage after $15 member Copay</td>
<td>$40 member Copay</td>
</tr>
<tr>
<td><strong>Retail Walk-in Clinic</strong></td>
<td>100% coverage after $20 member Copay</td>
<td>100% coverage after $30 member Copay</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>(e.g., CVS Minute Clinic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>100% coverage after $50 member Copay</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>100% coverage after $50 member Copay</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>(Office Visits and Outpatient services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Applied Behavior Analysis Therapy (1)</strong></td>
<td>100% coverage after $50 member Copay</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td>100% coverage after $50 member Copay</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>(Office Visits and Outpatient services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Testing</strong></td>
<td>100% coverage after $20 member Copay</td>
<td>100% coverage after $30 member Copay</td>
<td>60% coverage after Deductible</td>
</tr>
</tbody>
</table>
### Allergy Treatment

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Treatment</td>
<td>100% coverage for allergy injections</td>
<td>100% coverage for allergy injections</td>
<td>100% coverage for allergy injections after deductible</td>
</tr>
</tbody>
</table>

1. These services require precertification. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties and restrictions.

### Physician Office Visits: Non-Network

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician (Non-Preventive Care Visit only)</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>

Note: The Plan does not provide coverage for Non-Network preventive health care services.
### Professional Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>For In-Network and Non-Network Coverage of Professional Services, the following limits (combined for In- and Out-of-Network) apply:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong> - limited to 60 visits per Plan Year for Rehabilitative Therapy or Habilitative Services combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong> - limited to 60 visits per Plan Year for Rehabilitative Therapy or Habilitative Services combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy</strong> - limited to 60 visits per Plan Year for Rehabilitative Therapy or Habilitative Services combined</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong> - limited to 30 visits per Plan Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture</strong> - limited to 30 visits per Plan Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Services</strong> (1) - 120 maximum per Plan Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong> (1) (Inpatient or Outpatient)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Network Coverage:</strong></td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Non-Network Coverage:</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>

(1) These services require precertification. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties and restrictions.

### Preventive Care

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well Baby Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Birth to 1 year old – 7 visits</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td>- 1 to 3 years old – 3 visits/year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 4 to 19 years old – 1 visit/year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Designated Preventive Immunizations</strong> (Refer to the “Preventive Care” section of this document. You may also call Aetna for a full list of designated preventive immunizations.)</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Preventive Screenings including related X-rays and Labs</strong> (1) (Refer to the “Preventive Care” section of this document.) (When performed during an Office Visit, Network Lab, or Urgent Care Center)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Non-Network Coverage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>
## Diagnostic Care

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-preventive or Non-routine Diagnostic Screenings including related Basic Imaging and Labs(^1)</strong>&lt;br&gt;(When performed at an ER, Ambulatory Surgical Center, Inpatient or Outpatient facility)</td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Complex Imaging Services(^2)</strong></td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Non-Network Coverage</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>

\(^1\) Basic Imaging and Lab services are covered at 100% in the Premium 80 and Select 70 Plan options when performed during an Office Visit, at an independent lab, or at an Urgent Care Center. In the Core 60 Plan option, members must meet the Deductible before these services are covered at 100% when performed in these settings. Basic Imaging and Lab services are subject to the above Deductible and Coinsurance when performed at an ER, Ambulatory Surgical Center, inpatient facility, or other outpatient facility. See “Covered Services” for more information about what services are considered Basic Imaging Services.

\(^2\) These services require precertification. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties and restrictions.

## Other Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment and Prosthetic Devices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation/Chemo Therapy(^1)</td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>Hemodialysis(^1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>In-Network Coverage</strong></td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Non-Network Coverage</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>

\(^1\) These services require precertification. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties and restrictions.
## Hospital & Facility Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Radiology at an Inpatient or Outpatient Facility</strong></td>
<td>(1) <em>(e.g., MRIs, MRAs, PET and CT scans, echocardiograms)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Services and Surgeries</strong> (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services/Ambulatory Surgery</strong> (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Services</strong> (1) - 120 day maximum per Plan Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Services</strong> (1) <em>(Inpatient or Outpatient)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong> (1) <em>(Inpatient or Outpatient)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong> (1) <em>(Inpatient or Outpatient)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>In-Network Coverage:</strong></th>
<th>80% coverage after Deductible</th>
<th>70% coverage after Deductible</th>
<th>60% coverage after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Network Coverage:</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>

(1) These services require precertification. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties and restrictions.

## Urgent Care Services

*Urgent care is considered to be treatment for non-life-threatening ailments after your doctor’s office is closed. This could be treatment for things like fractures, whiplash, sport injuries, falls (less than 7 feet), cuts and minor lacerations, allergies, infections, flu, gallstones, burns, or rashes. Urgent Care Centers are generally free-standing facilities in busy areas and are staffed by doctors with extended and weekend hours.*

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>100% coverage after $40 member Copay</td>
<td>100% coverage after $60 member Copay</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td><strong>Non-Network Coverage</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>
## Emergency Services: In-Network & Non-Network

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
</table>
| **Emergency Room**
   *(including ER Physician)*          | 80% coverage after $150 member Copay, subject to Deductible (waived if admitted to Hospital) | 70% coverage after $250 member Copay, subject to Deductible (waived if admitted to Hospital) | 60% coverage after Deductible |
| **Ambulance**                         | 80% coverage after Deductible | 70% coverage after Deductible | 60% coverage after Deductible |

1. Emergencies include: fractures, head injury, knife or gunshot wound, or a severe burn; non-accidental, but critical life-threatening situations (e.g. heart attack, stroke, acute asthma attack, etc.); sudden onset of symptoms (loss of consciousness, paralysis, shock, coughing blood, trouble breathing, chest pain, choking) that suggest a serious or life-threatening situation could develop if left untreated; and serious or life-endangering Mental Health or Substance Abuse situations.

If participants obtain emergency care in an emergency room and their symptoms did not indicate an emergency, no benefits will be paid. If participant is admitted to the Hospital or if surgery is performed, Aetna’s Medical Management group needs to be notified within 48 hours of an emergency admission.

2. Precertification is required for ambulance services only in the case of a non-emergency. Refer to the “Precertification of Services” and “Precertification Penalties” sections for precertification requirements, penalties, and restrictions.
### Family Planning Services

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 Plan Pays</th>
<th>Select 70 Plan Pays</th>
<th>Core 60 Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity Services: In-Network</strong></td>
<td>Prenatal Office Visits are covered at 100% per visit, no Copay or Deductible applies. Lactation Support and Counseling Services (limit 6 visits per Plan Year).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity-related Basic Imaging and Lab Services</strong></td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage after Deductible (No deductible applies to preventive care lab services)</td>
</tr>
<tr>
<td><strong>Other Maternity Expenses: In-Network</strong></td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>- In-Network Hospital/Facility Charges (covered under the Hospital benefit)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Delivery and Newborn Charges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Network Maternity Expenses (All)</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
<tr>
<td>Associates and their Spouse/Domestic Partner who are enrolled in the Plan are eligible to participate in Aetna’s Beginning Right Maternity Program and receive a Wellness Bonus of up to $150. This program is free to covered Associates/Spouses/Domestic Partners and provides a great resource for health information and assistance during pregnancy. Call Aetna at (866) 498-5004 to enroll.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Family Planning Services: In-Network</strong></td>
<td>80% coverage after Deductible</td>
<td>70% coverage after Deductible</td>
<td>60% coverage after Deductible</td>
</tr>
<tr>
<td>- Voluntary Termination of Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Infertility Services (Covers diagnosis &amp; treatment of underlying cause only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Vasectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Some contraceptive services may be covered at 100% under “Preventive Care” – see that section for more information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Female Sterilization</strong></td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
<tr>
<td><strong>Other Family Planning Services (including Female Sterilization): Non-Network</strong></td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
<td>50% coverage after Deductible</td>
</tr>
</tbody>
</table>
### Prescription Drug Program Highlights

Please refer to the Prescription Drug Program section for more information.

<table>
<thead>
<tr>
<th>Plan Provision</th>
<th>Premium 80 You Pay</th>
<th>Select 70 You Pay</th>
<th>Core 60 You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Not subject to Plan Deductible)</td>
<td>(Not subject to Plan Deductible)</td>
<td>(Subject to Plan Deductible)²</td>
</tr>
<tr>
<td>Retail Pharmacy (Up to a 30-day supply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 Copayment</td>
<td>$15 Copayment</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td>Preferred Brand²</td>
<td>$35 Copayment</td>
<td>30% coinsurance Min. $40 / Max $100</td>
<td>40% coinsurance Min. $50 / Max $125</td>
</tr>
<tr>
<td>Non-Preferred Brand²</td>
<td>$55 Copayment</td>
<td>30% coinsurance Min. $60 / Max $150</td>
<td>40% coinsurance Min. $70 / Max $175</td>
</tr>
<tr>
<td>Maintenance Choice (Up to a 90-day supply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20 Copayment</td>
<td>$30 Copayment</td>
<td>$40 Copayment</td>
</tr>
<tr>
<td>Preferred Brand²</td>
<td>$70 Copayment</td>
<td>30% coinsurance Min. $80 / Max $200</td>
<td>40% coinsurance Min. $100 / Max $250</td>
</tr>
<tr>
<td>Non-Preferred Brand²</td>
<td>$110 Copayment</td>
<td>30% coinsurance Min. $120 / Max $300</td>
<td>40% coinsurance Min. $140 / Max $350</td>
</tr>
<tr>
<td>Non-Network Pharmacies</td>
<td>Participant pays full retail price and files a paper claim with CVS Caremark. Reimbursement will be for the wholesale cost (as determined by CVS Caremark) of the drug less the Copayment applicable to Network Pharmacies.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(1) Unless your prescription is on Caremark’s Preventive Drug List, in which case, your Copayment or Coinsurance is not subject to the Deductible. See the “Prescription Drug Program” section or contact Caremark Member Services at (855) 361-8564 for additional information.

(2) If you request a Preferred or Non-Preferred Brand name drug when either a Generic equivalent or Generic exact alternative drug is available, the Plan may only cover the Generic equivalent or Generic exact drug.

- If you fill the Brand drug, you may be responsible for the full cost or the difference in the cost between the Brand and Generic drug, depending on the drug type, in addition to the higher Copayment.
- If your doctor requests a Preferred Brand or a Non-Preferred Brand name drug when a Generic is available (for example, if your doctor designates “dispense as written” on the prescription.), you must obtain preauthorization from CVS Caremark first in order for the Brand drug to be covered.
- If medical necessity is established during the preauthorization, the Brand drug will be covered at the level shown in the above chart. See the “Prescription Drug Program” section or contact Caremark Member Services at (855) 361-8564 for more details.

(3) Maintenance Medications are required to be filled with a 90-day supply through a CVS retail pharmacy or CVS Caremark Mail Service Pharmacy. See the “Prescription Drug Program” section or contact Caremark Member Services at (855) 361-8564 for more details.
Medical Plan Provisions

Plan Year Deductible

The Plan Year Deductible is the amount of Covered Expenses you must pay each Plan Year before the Plan begins to pay benefits.

- Covered expenses are subject to separate Deductibles for Network and Non-Network services. Network and Non-Network Plan Year Deductibles accumulate separately. Covered Expenses applied toward the Network Deductible do not apply to the Non-Network Deductible and vice versa.
- Both Medical and Prescription out-of-pocket expenses apply toward the same Deductible.

Special Provisions for the Premium 80 and Select 70 Deductible:

- The Individual Plan Year Deductible applies separately to each Participant, each Plan Year, unless the Family Plan Year Deductible is satisfied.
- The Two-Person Plan Year Deductible is satisfied when the Associate and his/her dependent each meet the Individual Plan Year Deductible.
- The Family Plan Year Deductible applies no matter how large the family and is satisfied when each of: (i) the Associate; (ii) the spouse/domestic partner; and (iii) all other covered dependents (combined) meet the Individual Deductible.
- For purposes of clarification, one member (or, in the case of family coverage, two members) cannot satisfy the total deductible for all members.
- All services covered at a percentage of the cost (coinsurance) are subject to the applicable Deductible before the Plan pays benefits, except that services covered at 100% (In-Network) are not subject to the Deductible.

Special Provisions for the Core 60 Deductible:

- Because the Core 60 option is a High-Deductible Health Plan (HDHP), the full Plan Deductible must be satisfied before the Plan begins to pay benefits. The full Plan Deductible is based on the coverage level you elect (e.g., Associate Only, Associate plus Child, Family), as there is no Individual Deductible on the Core 60 Plan option when you enroll in a coverage level that includes dependents.
- Basic Labs and Imaging services are only subject to coinsurance after you reach your full Deductible. You will pay 100% of the cost of these services prior to reaching your full Deductible.
- Preventive Care services, as defined by regulations under the Affordable Care Act, will be covered at 100% In-Network and you are not required to meet your Deductible for these services to be covered at 100%. (Preventive Care services are covered Out-of-Network at 50% coinsurance and subject to the Deductible.)

Copayments

Copayments (or “Copays”) are flat dollar amounts that you pay for a specific service received from a Network Provider. Please refer to the coverage chart for information about the Copayments applicable to the Plan option in which you are enrolled.

- A Copayment applies to office visits with a Primary Care Physician (PCP)*, Urgent Care Center, Teladoc or a Retail Walk-in Clinic in the Premium 80 and Select 70 Plan options.
- If you are enrolled in the Premium 80 Plan option, a Copayment also applies to office visits with a Network Specialist, Mental Health Provider or Substance Abuse Provider.
- A Copayment will be charged for Emergency Room visits in the Premium 80 and Select 70 Plan options, in addition to Coinsurance on the remainder of the charges, after your Deductible has been satisfied. However, the ER Copay will be waived if you are admitted to the Hospital for treatment.
- The Copayment covers the cost of the basic “office visit,” but may not cover the entire cost of the visit if services are performed during the visit that are subject to the Deductible and Coinsurance.

* There is no Copayment applicable to an In-Network office visit in which only Preventive Care services are performed by a Primary Care Physician. Please call Aetna at (866) 498-5004 to find a doctor who participates in the Network, or go to aetna.com - “Find a Doctor.”
Coinsurance

Coinsurance is the percentage of Covered Expenses that you pay after the Plan’s Deductible has been satisfied. For example, if you are enrolled in the Premium 80 Plan option and receive services at a Network Hospital, you pay 20% of eligible expenses (the Plan pays the remaining 80%) after you have met the applicable In-Network Plan Year Deductible. Please note that the Coinsurance percentage varies based on the Plan option you are enrolled in and the service involved. Please refer to the coverage chart for more information about your Plan option.

Out-of-Pocket Maximum

To protect you from large medical bills resulting from serious illness or injury, the Plan places a cap on the maximum you can pay in Copays, Deductibles and Coinsurance in a Plan Year. When you reach this amount, called the Out-of-Pocket Maximum, the Plan pays 100% of Covered Expenses for the remainder of that Plan Year. Your expenses for both medical services and prescriptions count toward the Out-of-Pocket maximums.


Recognized (or Reasonable & Customary) Charges

When you use Non-Network Providers, benefits are subject to a Recognized Charge (also referred to as a “Reasonable & Customary Charge”). This means that the Plan will pay up to the Recognized Charge, as determined by Aetna. If your Non-Network Provider’s actual charge is above the Recognized Charge, you are responsible for the difference. These charges do not count towards satisfying Deductibles and Out-of-Pocket Maximums. Please note that you do not need to be concerned with Recognized Charges if you use a Network Provider.

Please refer to the “Recognized Charges” section of the Glossary for more information.

Pre-Treatment Estimates

Before receiving diagnostic or treatment services, please have your doctor submit a voluntary pre-treatment estimate to Aetna. This will provide you with the costs for the recommended services, including your out-of-pocket costs, and Aetna can help you make the best decisions about the health care services that are right for you.

Call Aetna at (866) 498-5004 to obtain information about your treatment options and the cost/coverage for those options. Note that these are estimates only. Whether the Plan covers a particular claim and at what level will depend on the facts of that claim. You must file a claim for benefits as described in the “Claims Information” section in order to receive benefits under the Plan.

Precertification of Services – Precertification Penalty

Certain services require precertification under this Plan. Examples of services that require precertification include (but are not limited to): inpatient or outpatient admissions or services, outpatient interventional pain management, inpatient or outpatient hip and knee procedures, Home Health Care, Hospice, Skilled Nursing Facilities, Applied Behavior Analysis Therapy, Complex Imaging services, transgender reassignment services and bariatric surgery. Please refer to the “Medical Plan Highlights” and “Covered Services” sections for information about specific services.

In-Network Services: You are not responsible for precertifying services provided by an In-Network provider. In-Network providers are responsible for obtaining the precertifications necessary for services under the Plan. Since precertification is the In-Network provider’s responsibility, there is no additional out-of-pocket cost to you as a result of an In-Network provider’s failure to precertify services.
Non-Network Services: You are responsible for contacting Aetna to initiate the precertification process for non-network services. Prior to receiving any health care services from a Non-Network Provider, you should call Aetna to confirm whether precertification is required or if the desired services are covered for Non-Network Providers. If you do not precertify, your benefits may be reduced or the Plan may not pay any benefits. Time limits may apply, as follows:

If seeking Non-Network treatment, you should contact Aetna for precertification in the following instances:

- as soon as possible, but prior to any scheduled inpatient or residential admission for medical, Mental Health or Substance Abuse treatment (except in the case of an emergency).
- within 48 hours after an unscheduled or emergency Hospital admission.
- Prior to certain scheduled outpatient tests/procedures/surgeries and services as indicated in the “Medical Plan Highlights” or “Covered Services” sections of this document.

For any non-emergency admissions, surgeries or services, the precertification request must be made at least 14 days prior to scheduled date.

If you or your provider files a claim for precertification, your claim will be processed under the pre-service claim rules discussed in the “Claims Information” section. If your precertification request is denied, you or your provider will have a right to file an appeal.

Contact Aetna’s Medical Management group at (866) 498-5004 for all precertification requests. If an unplanned admission in a Non-Network facility occurs after hours or on a weekend or holiday, call on the first business day following the admission. It is your responsibility to satisfy precertification requirements for Non-Network services.

Precertification Penalty

A penalty of $500 applies to certain Non-Network services such as Hospital admissions (except for emergencies) and Alternative Health Care Services (Home Health Care, Hospice and Skilled Nursing Facility) for which pre-certification was required but not obtained. It is your responsibility to ensure that precertification is completed prior to receiving such Non-Network services. Please refer to the “Precertification of Services” section for more information.

The Precertification Penalty applies separately to each Participant for each occurrence. It does not count toward any Deductible or Out-of-Pocket Maximum.

Aetna HealthFund Account (Select 70 Only)

If you participate in the Select 70 Plan option, CarMax will contribute $200, $400 or $600 to your Aetna HealthFund Account based on your coverage election. The HealthFund is a Health Reimbursement Account (HRA) that helps pay for eligible out-of-pocket expenses such as Copays or your Deductible. For In-Network services, the HealthFund will automatically pay eligible expenses at the time your medical claims are processed. You may also request reimbursement for eligible expenses paid out of your pocket, such as for prescription costs.

You and your covered dependents may use the Aetna HealthFund Account for payment of Covered Expenses up to the full annual HealthFund amount. Please note that if you enroll in the Plan mid-year, your HealthFund amount will be prorated based on the number of full months that you participate in the Select 70 Plan option. Any unused balance in your HealthFund at the end of the Plan Year may be rolled over for up to two additional Plan Years provided you remain enrolled in the Select 70 Plan option.

Please note that if you use the HealthFund to pay for eligible expenses of a Domestic Partner who is not your tax dependent, such funds must be imputed to your income when you file your taxes. Please see the Domestic Partner Benefits Policy on the CarMax Benefits website for more detailed information.
Health Savings Account (Core 60 Only)

If you participate in the Core 60 Plan option, which is a High-Deductible Health Plan (HDHP), you have the option to participate in a Health Savings Account (HSA), as long as you meet certain eligibility requirements set by IRS regulations. For example, you are not eligible to participate in an HSA: (i) if you are enrolled in Medicare, TRICARE, or a non-HDHP health plan; (ii) if you or your spouse have a general health care FSA; (iii) if you receive health care benefits from the Veterans Administration during the past three months, unless the benefits are due to a service-related disability; or (iv) if you are someone else’s tax dependent. You are responsible for determining whether you meet the HSA eligibility requirements.

If you elect to participate in the Health Savings Account, CarMax will contribute $200, $400, or $600 to your account based on your coverage election at the time of enrollment in the HSA. The HSA can be used to cover out-of-pocket expenses for health care services, including your Medical Plan Deductible, when they are incurred, or, you can pay such expenses out of pocket and save your HSA monies for future use.

Please refer to the CarMax Benefits website for answers to common questions and to IRS Publication 969 for more information. You may also wish to consult your tax advisor.
Choosing the Right Place and Provider for Care

When you need care, you have choices about which provider you select for the care that you need. Your choice makes a difference! It will impact how much you pay out of pocket and how much the plan pays towards the cost of care. Making the best choice for you starts with finding a Network Provider.

Network Providers

Aetna offers Network Providers throughout the United States. In-Network services are provided through the Aetna network named “Aetna Choice POS II (Open Access).”

You have the flexibility to use Network or Non-Network Providers, but benefits will be subject to a higher Deductible, Coinsurance and Out-of-Pocket Maximum when using Non-Network Providers and you could be billed for the balance of amounts that are above Recognized Charges. Network Providers help you use your health care dollars more efficiently through:

- Network discounts
- Lower Deductibles and Coinsurance
- Lower Out-of-Pocket Maximums
- Waiving charges that exceed Recognized Charges as determined by the Plan

In addition, Network Providers automatically file claims with Aetna on your behalf.

The Plan does not guarantee that all Covered Services are available at In-Network levels or that access to a Network Provider will be available in all geographic areas.

Aetna cannot guarantee the availability or continued participation of a particular provider. Either Aetna or any Network Provider may terminate the provider contract or limit the number of patients accepted in a practice.

A covered expense you have incurred with a Non-Network Provider may be treated as a Network expense, subject to the maximum allowable charge, for laboratory, anesthesia, radiology, or pathology services, but only if such services are provided at a Network Hospital in connection with care from a Network Provider. If applicable, the plan will cover these services at the In-Network coinsurance rate that applies to the Plan option in which you are enrolled.

A Special Note about Sutter Health and Affiliates

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna’s contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). As a result, these claims may be processed differently than similar claims made by other providers who are In-Network.

Finding Network Providers

You can find Network Providers in your area or find out if your providers participate in the Aetna Network by calling Aetna at (866) 498-5004 or by checking online at aetna.com “Find a Doctor.”

IMPORTANT NOTE: It is the member’s responsibility to verify whether any provider is participating in the Aetna Choice POS II (Open Access) Network at the time of service. This Network of providers applies to all three Plan options.

Aetna 24-Hour Nurse Line: 1-800-556-1555

Aetna offers Plan members a free 24-hour nurse line (Informed Health Line) to help you anytime day or night. The nurses can help you determine if you need immediate care or if you can wait to see your doctor during normal business hours and help you with minor health issues.
Primary Care Physicians (PCP)

While you do not have to “designate” a Primary Care Physician (PCP), we strongly encourage you and your family members to establish a relationship with a PCP.

A PCP is a Family or General Practitioner, Internist, Pediatrician or an OB/GYN.

A PCP can analyze your family’s history and medical background, which is crucial in recommending an appropriate treatment plan. PCPs are trained to treat a wide variety of common illnesses and they typically charge less than Specialists for services. Although referrals are not required under this Plan, PCPs are also an excellent source for Specialist referrals should specialized treatment be necessary. To receive the highest level of benefits, be sure to verify that your PCP or any provider you use is a Network Provider before you make an appointment. If you need help finding a provider that is right for you, call Aetna at (866) 498-5004. The Aetna Health Concierge can help you find a doctor so you can establish a relationship as soon as possible.

Teladoc Program

Teladoc is the largest provider of telehealth medical consultations in the U.S. Through Teladoc, you have 24/7/365 access to medical care through phone and video consultations. Teladoc should not replace your primary care physician. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many of your medical issues, such as sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infection, skin conditions and rashes, or ear infections.

To use the program, you must set up an account on the Teladoc website: www.teladoc.com/aetna and complete a brief questionnaire. Once you have an account, you can request a consultation online, through the Teladoc “app” or by calling Teladoc at (855) TELADOC (1-855-835-2362). You have the option to request a telephone consultation or a video consultation through an application on your phone or computer.

IMPORTANT NOTE: Some states prohibit online and/or telephone physician consultations. For example, telephonic consultations are prohibited in Idaho and Arkansas, and video consultations are prohibited in Idaho, Arkansas, Iowa, Louisiana, Missouri, Ohio, and Texas. Other state limitations may apply.

Retail Walk-in Clinics

Retail Walk-in Clinics are typically found in retail businesses such as CVS Pharmacies, Target stores, or Walgreens Pharmacies. These clinics are run by either RNs, Nurse Practitioners, or Physician Assistants. You should consider a Retail Walk-in Clinic when you have the need for immediate care that is not urgent – examples include the treatment of cold/flu symptoms, rashes, or basic infections. You can also get many wellness exams and routine physicals.

To find a Retail Walk-in Clinic near you, log into aetna.com and click on Find a Doctor. CVS, Target and Walgreen clinics are Network Providers.

Aexcel Specialist Network

Aetna Aexcel specialists are those specialists nationwide who meet Aetna’s qualifications of excellence on a variety of measures, including diagnosis, lab tests, clinical performance, surgery, follow up care, and cost efficiency. When you visit an Aexcel-designated specialist, you can be confident that you’re receiving quality care. These designated specialists have shown that they deliver cost-effective care with fewer complications and repeat procedures.

Aexcel specialists practice in the following key areas:

- Cardiology
- Cardiothoracic surgery
- Gastroenterology
- General surgery
- Neurology
- Neurosurgery
- Orthopedics
- Otolaryngology (ear, nose and throat)
- Plastic surgery
- Urology
- Vascular surgery

The Aexcel Network is not available in all areas. Aexcel specialists are identified on aetna.com – “Find a Doctor” with a blue star on the results page. You can also call Aetna at (866) 498-5004 for help finding a doctor that’s right for you.

**Urgent Care**

Urgent Care is treatment for non-life-threatening injuries or illnesses such as fractures, sprains, sports injuries, cuts and minor lacerations, allergic reactions, infections, flu, gallstones, minor burns or rashes.

Call your Primary Care Physician first if you think you need urgent care. Network Primary Care Providers are required to have physicians available or on call 24 hours a day, including weekends and holidays. Your physician can help you determine how to receive the most appropriate care for your situation. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided.

Urgent Care clinics are freestanding buildings in busy areas. They typically have a physician on site and accept walk-ins. Costs are typically higher than a Primary Care Physician office visit, but are much less than an Emergency Room visit.

If you need help finding an In-Network Urgent Care Clinic you may call Aetna at (866) 498-5004 or by checking online at aetna.com - Find a Doctor.

**Emergency Medical Care**

If you need Emergency Medical Care, you may not have a choice about the facility you use. For this reason, if you go to a Non-Network Hospital in an emergency, the Plan will pay the charges as if you had gone to a Network Hospital.

“Emergency Medical Care” is defined as medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, where the symptoms are severe enough that the lack of immediate medical attention could reasonably be expected to result in the patient’s health being placed in serious jeopardy, bodily functions being seriously impaired, serious dysfunction of a bodily organ or body part, or death.

*Examples of emergencies include: broken bones; head injuries; knife or gunshot wounds; severe burns; non-accidental but critical life-threatening situations such as heart attack, stroke, and an acute asthma attack; sudden onset of symptoms that suggest a serious or life-threatening situation such as chest pains; or a life endangering Mental Health or Substance Abuse emergency.*

If an emergency situation occurs, you should seek immediate care. Contact Aetna as soon as possible or you can have someone call on your behalf.

Emergency services will be paid at the In-Network level after the Plan’s Deductible and the required Copayment (Copayment waived if admitted). Emergency services includes the Physician charge, Hospital facility charge, ambulance charge, and charges for any related services and supplies needed during the emergency care when charges for these services and supplies are billed by the Hospital or Physician. However, if treatment is sought in an emergency room and it is later determined that emergency treatment was not necessary, no benefits will be paid.

*Follow Up Care After Treatment of an Emergency or Urgent Medical Condition:*

Follow up care is not considered an emergency or urgent condition and is not covered as part of an emergency or urgent care visit. Once you have been treated and discharged, you should contact your Primary Care Physician for any necessary follow up care.
Medical Care while Traveling

If you need treatment for minor medical conditions while traveling, you should contact Aetna at the number on your ID card to find a Network Provider in the area. You should contact your doctor as soon as you return home for any follow-up care.

If you need medical services when outside the U.S., you should access the care you need. As long as the medical services are covered under the Plan, they will be covered at the In-Network level. You must pay for services and are responsible for submitting claims requesting reimbursement to Aetna. You will be responsible for amounts charged above the Plan’s Recognized Charges as determined by Aetna.

If you need to fill a prescription when outside the U.S., the drug must be FDA-approved and covered under the Plan to be eligible for reimbursement under the Plan. You are responsible for paying the cost of the prescription and submitting claims to CVS Caremark. Reimbursements will be based on the cost of the prescription minus the applicable Copayment or Coinsurance.
Aetna Programs and Resources

The Plan’s Medical coverage is administered by Aetna. The Plan provides you with an array of programs, resources and services to help you and your family take charge of your health.

Aetna Navigator - A Secure Member Website

Aetna Navigator Secure Member Website is an online resource for personalized health and financial information. Available 24/7, Aetna Navigator® helps you see who is covered under your plan, find health care professionals (doctors, hospitals, labs), request a member ID card, track claims and review health and wellness information. Your covered dependents can also visit the site to access certain features. Visit Aetna at aetna.com to learn more about the features and benefits of Aetna Navigator.

The Aetna website may contain additional information to help you determine the cost of a service or supply. Simply access the “Estimate the Cost of Care” feature on the website. Within this feature, you can view the “Cost of Care” and “Member Payment Estimator” tools.

Health Concierge

You may use the Aetna Health Concierge as your single point of contact for all the Aetna programs, including the Medical Plan. The Health Concierge takes a “whole person” approach to helping you navigate your health and the health care system, and provides tools and resources to help you get valuable information about the Aetna programs available. Please contact the Health Concierge at (866) 498-5004 with any questions about your benefits or the programs being offered through CarMax.

Health Care Advocate

You may use an Aetna Health Care Advocate to help you or a covered dependent with a serious illness or injury. A Health Care Advocate can identify and coordinate cost-effective care alternatives that meet quality medical standards, monitor appropriate patient care, and coordinate communications between the patient and the doctors while providing emotional support to the patient’s family.

A Health Care Advocate can assist you and your doctors in determining the most appropriate care needed. In all instances, the final decision of what treatment to use rests with you and your doctors.

The Health Care Advocate can be reached by calling (866) 498-5004. The Health Care Advocate hours of operation are 8:00 a.m. to 6:00 p.m. (local time to the Associate), Monday through Friday.

Autism Advocate Program

The Autism Advocate Program is a voluntary, free program for families who have a dependent who is diagnosed with an Autism Spectrum Disorder (ASD). Aetna will assign a dedicated Autism Advocate for you and your family. This behavioral health clinician is specifically trained in ASD and is the single point of contact to help families affected by an autism diagnosis by:

- Addressing questions about autism benefits, and the Applied Behavior Analysis (ABA) therapy authorization process
- Finding providers
- Resolving claim issues
- Assuring that treatment is effective
- Connecting parents to available resources
- Coordinating with integrated Autism Care providers and supports.

The Autism Advocate by be reached by calling the Aetna Health Concierge at (866) 498-5004.
Aetna In Touch Care

The Aetna In Touch Care Program is a voluntary, free program available to those who participate in the Plan. In Touch Care is designed to help individuals manage and live with chronic health conditions, such as high blood pressure or high cholesterol.

Because most patients see more than one doctor for their various medical conditions, it can be difficult for one doctor to know everything about them. The In Touch Care Program uses technology to analyze health care information from all of your providers. This technology along with member involvement provides you the opportunity to improve treatment for specific conditions. Examples of these conditions include: diabetes, asthma, congestive heart failure, and coronary artery disease. You will have the opportunity to work one-on-one over the phone with your own personal "Health Coach/Nurse," who will:

- Help you better understand your healthcare needs
- Advise you on topics to discuss with your doctors
- Help you understand your treatment options

Through the In Touch Care Program you will receive specific information about opportunities to improve your health and the care you receive. This information can help you make better use of your time with your doctor and how you can improve your health through changes in treatment or your lifestyle. As part of this program, you may periodically receive the following:

- A Care Consideration: A Care Consideration is a letter with information about your health that is sent to members to be discussed with the Health Coach as well as your doctors.
- A Personal Health Record: A Personal Health Record gives you an at-a-glance view of your health. It can include information about your health condition(s), your health improvement goal(s), questions for you to ask your doctor, and resources for additional health information.
- Health Education Material: General health information that will help you answer questions and concerns you may have about your health.

You are encouraged to share this information with your doctor(s) and discuss what steps, if any, might be appropriate to improve your health.

The information used by the In Touch Care Program is completely confidential. Members are protected by all federal and state health privacy laws. You may contact Aetna directly at (866) 498-5004.

Beginning Right Maternity Program

Beginning Right is a voluntary, free, and comprehensive maternity program to help you take care of yourself and your baby during your pregnancy. Beginning Right promotes healthy pregnancies and babies and identifies members with high-risk pregnancy. You will receive educational materials about pregnancy and related issues and have access to specially trained obstetrical nurses who work in conjunction with you and your Physician to provide appropriate prenatal care. The program includes an early risk assessment (survey) to provide the proper education and assistance necessary to maintain good health throughout the pregnancy.

CarMax provides a financial incentive up to $150 to Associates or Spouses/Domestic Partners who are enrolled in the Medical Plan and participate in the Beginning Right program. Please refer to the Maternity Incentive Policy on the CarMax Benefits website for more information. You can register for the Beginning Right program by calling (866) 498-5004.

NeoCare Solutions

NeoCare Solutions is designed to help parents of children in the neonatal intensive care unit (NICU) by engaging, supporting, educating, and empowering you to become confident caregivers while your child is in the NICU and back at home. NeoCare combines mobile technology with NICU trained coaches. With simple access to an enhanced level of guidance, support and empowerment, you may ultimately have a greater ability to understand your child’s health and health care needs, safely get your baby home sooner and avoid unnecessary future readmissions.

Participation in this program is free to members. To enroll in the program, you can call the Aetna Health Concierge at (866) 498-5004; Aetna may also contact you directly.
**Aetna Discount Programs**

Aetna offers discount programs so you have access to special discounts on a number of services that are not traditionally covered under a health benefit plan. This program provides discounts at gyms, eyewear, hearing aids, weight loss programs, and more. Information about the available discounts is available at [aetna.com](http://aetna.com), click on Individuals & Families and then Health and Wellness Products and Services. You can also call Aetna at (866) 498-5004 for more information.
Preventive Care

The Plan provides coverage for preventive health care services when performed by Network Providers. For services provided outside of the age limits noted or in excess of what has been defined here, coverage will be subject to the standard In-Network Coinsurance level after the applicable Deductible is met, provided services are allowed by Aetna’s medical policy.

Under the Affordable Care Act (the “ACA”), the Plan is required to cover certain preventive care services, including women’s health preventive services. The Plan provides medical and prescription drug coverage in compliance with the applicable components of the ACA. Additionally, as required by the ACA, preventive services will be paid without cost-sharing (such as Copays, Coinsurance and Deductibles) – meaning they are covered at 100% -- when such services are performed by In-Network Providers.

All coverage amounts provided below are for services from In-Network Providers only.

If you obtain preventive care services from a Non-Network Provider, covered services will be subject to the standard Non-Network coinsurance (50%) and the applicable Non-Network Plan Deductible.

Preventive care services include the following:

- Items and services that have a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). The most recent copy of these items and services are available online at: [http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines support by HRSA, to the extent not already included in the current recommendations of the USPSTF.

Covered Preventive Services for Adults

Please note: The section below includes samples of preventive services for adults. For the full list of preventive services covered at 100% when performed In-Network, please visit: [http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)

If you have questions about coverage or preventive care services, including immunizations, please call Aetna at 866-498-5004.

Please also note: All coverage amounts provided below are for services from In-Network Providers only. If you obtain preventive care services from a Non-Network Provider, covered services will be subject to the standard Non-Network coinsurance (50%) and the applicable Non-Network Plan Deductible.

**Alcohol and/or Drug Screening and Counseling**: Covered at 100% for up to five one-hour visits.

**Annual Physical Exam**: Covered at 100%, no Copay or Deductible applies. The Plan provides each member age 19 and over with coverage for one routine annual physical examination each Plan Year. 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.

**Aspirin**: Covered at 100% for adults ages 50 to 59 who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

**Blood Pressure Screening**: Covered at 100%.

**Cholesterol Screening**: This screening for adults of certain ages or at higher risk is covered at 100%. Screenings are not subject to frequency limits.
**Colorectal Cancer Screening:** Preventive or diagnostic services for the following routine colorectal cancer screenings are covered at 100%:

- Fecal occult blood tests (covered at 100% if performed as part of a Physician’s office visit);
- Digital rectal exams;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

In addition, these benefits are not subject to any age or frequency limits. NOTE: Does not include MRIs which must be Medically Necessary and are subject to the Plan Deductible and Coinsurance.

**Depression Screening:** Covered at 100% for all members ages 12 and up.

**Diabetes Screening:** Preventive or diagnostic services are covered at 100%. Screenings are not subject to frequency limits.

**Hepatitis B Screening:** Covered at 100% for adults at high risk.

**Hepatitis C Screening:** Covered at 100% for adults at high risk

**HIV Screening:** Covered at 100% for all adults.

**Immunizations:** Covered at 100% for preventive immunizations (as determined by the USPSTF) for adults; no Copay or Deductible applies:

- hepatitis (A and B),
- influenza,
- human papillomavirus (HPV),
- pneumococcal,
- meningococcal,
- tetanus, diphtheria, pertussis
- measles, mumps, rubella,
- herpes zoster,
- varicella,
- haemophilus influenza type B.

Please note that some immunizations have age and frequency limitations for coverage.

**Obesity Screening and Counseling:** Covered at 100% for all adults for up to 26 one-hour visits, only 10 of which may be for healthy diet counseling provided in connection with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease conditions. Other elements of counseling include: risk factor reduction, medical nutrition therapy, and nutrition counseling.

**Prostate specific antigen (PSA) tests:** Covered at 100% if performed as part of a Physician’s office visit.

**Vitamin D:** Covered at 100% for participants age 65 and older (prescription required).
Covered Preventive Services for Women, Including Pregnant Women

Please note: The section below includes samples of preventive services for women. For the full list of preventive services covered at 100% when performed In-Network, please visit: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

If you have questions about coverage or preventive care services, including immunizations, please call Aetna at 866-498-5004.

Please also note: All coverage amounts provided below are for services from In-Network Providers only. If you obtain preventive care services from a Non-Network Provider, covered services will be subject to the standard Non-Network coinsurance (50%) and the applicable Non-Network Plan Deductible.

BRCA Counseling About Genetic Testing: Covered at 100% for women at higher risk. If indicated after counseling, BRCA testing is also covered at 100%.

Breast Cancer Chemoprevention Counseling: Covered at 100% for women at higher risk.

Breast Cancer Mammograms (not including MRIs): Covered at 100%. In addition, this benefit is not subject to any age or frequency limits. NOTE: Does not include MRIs which must be Medically Necessary and are subject to the Plan Deductible and Coinsurance.

Breast Cancer Risk-Reducing Prescription Medications: These medications (such as tamoxifen or raloxifene) must be covered at 100% for certain women at increased risk for breast cancer.

Cervical Cancer Screening: Covered at 100%.

Contraceptive Counseling and Methods (for women): Two Office Visits for contraceptive education and counseling per month during the Plan Year are covered at 100% for female members if such services are performed by a Physician, obstetrician or gynecologist. Female contraceptives approved by the Food & Drug Administration and prescribed by a Physician, obstetrician or gynecologist are covered at 100% (for generic only, when available, and brand-name contraceptives when medically necessary) for female members. If your attending physician believes a brand-name contraceptive is medically necessary, you may file a claim for coverage of the brand-name drug. Covered female contraceptives are:

- oral contraceptives (including combined pill, progestin only, and extended/continuous use) (generic only covered at 100%, when available);
- emergency contraception (including Plan B and Ella);
- injectables;
- implantable devices (IUD copper, IUD with progestin, and subdermal rods) and vaginal rings;
- transdermal patches;
- barrier methods (diaphragms and cervical cap);
- sponge, female condom, and spermicide; and
- voluntary sterilization (for women) procedures (surgery and implant) and related services and supplies.

Osteoporosis Screening: Covered at 100% for women over age 65, and younger women depending on risk factors.

Prenatal Care: The following prenatal care is covered at 100%:

- Physician, obstetrician, or gynecologist’s Office Visit covered at 100% with an In-Network provider if primary purpose of the Office Visit is to obtain services listed below, and services listed below are not billed separately from the Office Visit,
- maternal weight, blood pressure, urine (bacteriuria screening), uterine size, and fetal heart rate check,
- glucose tolerance/gestational diabetes screening,
- screening for certain sexually-transmitted infections (including syphilis),
- screening for certain genetic or developmental conditions (including Rh incompatibility),
- tobacco and nutrition counseling
• anemia screening
• Hepatitis B screening
• Folic acid supplements are covered at 100% at a Network pharmacy
• Aspirin (low dose) is covered at 100% at a Network pharmacy for women 12 weeks pregnant who are at high risk for preeclampsia (prescription required).
• Breastfeeding supplies and counseling:
  - Covered participants may obtain up to six lactation counseling visits per Plan Year during pregnancy and the duration of breastfeeding at 100% coverage; additional visits in a Plan Year are subject to the Deductible and applicable Coinsurance.
  - The rental of an electric breast pump (where the infant required a hospital stay) or the purchase of an electric or a manual breast pump, along with the accessories and supplies needed to operate the pump, are covered at 100%. Breast pump coverage is limited to one purchase per pregnancy. Additionally, the purchase of an electric breast pump will only be covered once every three years, regardless of the number of pregnancies during that time period, although new supplies will be covered for each pregnancy.

Screenings for Sexually Transmitted Diseases: Covered at 100% for younger women and other women at higher risk, including screenings for chlamydia infection and gonorrhea.

Well Woman Preventive Visit: Covered at 100%, no Copay or Deductible applies. Well woman visit includes examinations for primary and preventive obstetrics and gynecological services. Cervical cancer/pap smear screenings are covered in conjunction with the well woman visit. Well woman visit does not include services which are for the diagnosis or treatment of a suspected or identified illness or injury. Not subject to age or frequency limits.

Covered Preventive Services for Children

Please note: The section below includes samples of preventive services for children. For the full list of preventive services covered at 100% when performed in-Network, please visit: https://www.healthcare.gov/preventive-care-children/

If you have questions about coverage or preventive care services, including immunizations, please call Aetna at 866-498-5004.

Please also note: All coverage amounts provided below are for services from In-Network Providers only. If you obtain preventive care services from a Non-Network Provider, covered services will be subject to the standard Non-Network coinsurance (50%) and the applicable Non-Network Plan Deductible.

Well Child Care:

Out of Hospital Visits:
- Birth up to 1st birthday: 7 visits
- Age 1 up to 3rd birthday: 3 visits per year
- Age 4 up to 19th birthday: 1 visit per year

Examples of preventive services covered during Well Child Care Office Visits coverage includes:
• Depression screening for adolescents once a year
• Developmental assessment for children under age 3
• Immunization vaccines for children from birth to age 18 — Diphtheria, tetanus, pertussis (DTaP and Dtap); Haemophilus influenzae type B; Hepatitis A; Hepatitis B; Human papillomavirus; Inactivated poliovirus; Influenza (flu shot); Measles; Mumps; Rubella; Meningococcal; Pneumococcal; Rotavirus; and Varicella. Doses, recommended ages and recommended populations vary.
• Physical examination (including height, weight, length, head circumference, weight for length, and body mass index)
• Vision screening for all children.

For more information regarding covered preventive services for children, please refer to the website listed above. You may also refer to the Bright Futures Guidelines for Children and Adolescents published by the American Academy of Pediatrics, which is available at brightfutures.aap.org/.
Mental Health & Substance Abuse

Our Mental Health and Substance Abuse services are administered by Aetna Behavioral Health. Services include confidential referrals and care management for you and your covered dependents for Mental Health or Substance Abuse Treatment. Please note that while Aetna can provide helpful advice, you are not required to go through Aetna to access behavioral health providers, nor are you required to obtain services from a Network Provider.

A “Mental Disorder” is an illness commonly understood to be a mental disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatric physician, a psychologist or a psychiatric social worker.

- Any one of the following conditions is a Mental Disorder under this plan:
  - Anorexia/Bulimia Nervosa.
  - Bipolar disorder.
  - Major depressive disorder.
  - Obsessive compulsive disorder.
  - Panic disorder.
  - Pervasive developmental disorder (including Autism).
  - Psychotic disorders/Delusional disorder.
  - Schizo-affective disorder.
  - Schizophrenia.
- Also includes any other mental condition which requires Medically Necessary treatment.

“Substance Abuse” is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (which terms are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered Dependents). Substance Abuse does not include conditions not attributable to a mental disorder that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

How the Aetna Behavioral Health Program Works

If you need information or help selecting a Mental Health or Substance Abuse Provider, call Aetna at (866) 498-5004. The program offers:

- Toll-free access to help and information 24 hours a day, 7 days a week
- Easy access to professional, personalized help
- A full range of Mental Health services
- Help in finding inpatient or outpatient providers for Mental Health and Substance Abuse Treatment
- A Network of carefully selected providers practicing in a wide range of specialties
- Confidentiality

An Aetna Behavioral Health Clinician will answer your call and help you to select a Licensed Mental Health or Substance Abuse Provider close to your home or work location that specializes in the treatment needed and also meets any other special requirements you may have.

An Aetna Clinical Case Manager will work with your provider to manage treatment. “Licensed Mental Health or Substance Abuse Provider” includes psychiatrists and psychologists, psychiatric nurses, certified social workers, and certified Substance Abuse and Mental Health Providers.

Besides offering quality care, the Aetna Behavioral Health Network Providers offer negotiated rates, which mean lower out-of-pocket costs.

Covered Mental Health Services

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers which are incurred in a hospital, psychiatric hospital, Residential Treatment Facility, or behavioral health provider’s office as follows:

**Inpatient Treatment:** Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or
Residential Treatment Facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

**Partial Confinement Treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting. Covered expenses for treatment outside of these settings will be determined based on Aetna’s Medical Necessity guidelines.

**Outpatient Treatment:** Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or Residential Treatment Facility. The Plan covers partial hospitalization services provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

NOTE: Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Please refer to the Precertification of Services section below.

**Covered Alcoholism and Substance Abuse Services**

Covered expenses include charges made for the treatment of alcoholism and substance abuse by behavioral health providers which are incurred in a hospital, psychiatric hospital, or Residential Treatment Facility as follows:

**Inpatient Treatment:** Covered expenses include room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or Residential Treatment Facility. Inpatient treatment includes treatment in a hospital for the medical complications of alcoholism or substance abuse (medical complications include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens, and hepatitis). Coverage includes treatment in a hospital, when the hospital does not have a separate treatment facility section.

**Outpatient Treatment:** The Plan covers partial hospitalization services provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcoholism or substance abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

**Partial Confinement Treatment:** Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting. Covered expenses for treatment outside of these settings will be determined based on Aetna’s Medically Necessary guidelines.

NOTE: Inpatient care must be precertified by Aetna. Please refer to the Precertification of Services section below.

NOTE: Detoxification services given prior to and independent of a course of psychotherapy or Substance Abuse treatment are not considered Mental Health treatment.

**Precertification of Services**

**In-Network Services:** Network Providers are responsible for obtaining the precertifications necessary for services under the Plan.

**Non-Network Services:** You are responsible for contacting Aetna to initiate the precertification process in the following instances:

- as soon as possible, but prior to any scheduled inpatient or residential admission to a Non-Network Hospital, psychiatric or Substance Abuse treatment center;
- within 48 hours of an unscheduled or emergency admission to a Non-Network Hospital, psychiatric or Substance Abuse treatment center.

If you do not receive precertification prior to admission to a Non-Network Hospital, psychiatric facility, or Substance Abuse treatment center (by the next business day after an unscheduled or emergency treatment), a Precertification Penalty of $500 will be applied to the covered charges.
Residential Treatment Facilities

Residential Treatment Facility (Mental Disorders)

A Residential Treatment Facility with respect to a Mental Disorder is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient’s illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Residential Treatment Facility (Substance Abuse)

A Residential Treatment Facility with respect to Substance Abuse is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient’s illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.
Mental Health and Substance Abuse Disorder Parity

The Plan intends to comply with the Mental Health Parity and Addiction Equity Act of 2008, as amended ("Parity Act"). Accordingly, financial requirements and treatment limitations of Mental Health and Substance Abuse disorder benefits under the Plan must be no more restrictive than those applied to medical and surgical benefits as required by the Parity Act. The criteria for Medical Necessity determinations under the Plan with respect to Mental Health or Substance Abuse disorder benefits will be made available by Aetna Behavioral Health upon request.
Prescription Drug Program

Our Prescription Drug Program is administered by CVS Caremark. The Program provides access to an extensive network of pharmacies across the country from which you can purchase prescription drugs at discounted prices. It also features a Maintenance Choice Program which is required for Participants who use maintenance medications for ongoing medical conditions. Maintenance Choice is a CVS Caremark program that allows members to obtain a 90-day supply of maintenance medications by either home delivery or by picking up at a CVS pharmacy.

Medical Plan Participants are automatically enrolled in the Prescription Drug Program. Please refer to the “Prescription Drug Program Highlights” section above for a summary of benefits.

Preventive Drug List (Core 60 Only)

Generally, enrollees in the Core 60 option must meet their Deductible before benefits are paid. However, prescriptions approved and used for preventive care may be covered with standard copayments while meeting your Deductible in High Deductible Health Plans, like the Core 60 Plan option. If your prescription is included in the Caremark Preventive Drug List, your prescription will be subject to the standard Copayment or Coinsurance (including minimums and maximums), even if you have not yet met your Plan Deductible.

The Caremark Preventive Drug List is available on the CarMax Benefits website benefits.carmax.com or at caremark.com. The Preventive Drug List is subject to change at any time.

ID Cards

Use your CVS Caremark ID card (NOT the Aetna ID card) when purchasing prescription drugs. Always present your ID card to the pharmacist when purchasing prescription medications.

New Plan Participants who purchase prescriptions before receiving their ID cards will need to pay for the prescription at the time of receipt and submit a claim form to CVS Caremark requesting reimbursement.

Obtaining Prescriptions at Local Pharmacies

CVS Caremark participating pharmacies can be found at caremark.com. You may also contact CVS Caremark’s Member Services at (855) 361-8564.

Maintenance Choice Program (required for maintenance medications)

Maintenance medications are required to be filled with a 90-day supply through a CVS retail pharmacy or the CVS Caremark Mail Services Pharmacy. The Maintenance Choice Program is a convenient and cost-effective means of receiving your Maintenance Medication prescriptions. Maintenance Choice lets you choose to receive your maintenance medications at a local CVS/pharmacy or by mail from the CVS Caremark Mail Service Pharmacy.

Choose one of four easy ways to start using the Maintenance Choice program:

1. In person – Bring your prescription to a local CVS/pharmacy location
2. By mail – Fill out and send in a mail service order form available at caremark.com
3. Online – Use the FastStart tool found on caremark.com/faststart to set up your prescription
4. By phone – Call FastStart at 1-800-875-0867 to speak with a CVS Caremark Mail Service Pharmacy representative.

Remember, if you’re not going to pick up your prescription at a local CVS/pharmacy, to:

1. Ask your doctor for two prescriptions. One prescription should be for a 30-day supply that you can fill at a local retail pharmacy.
2. The second prescription should be for a 90-day supply with up to one year of refills (if appropriate) that you can send in to be filled through the Maintenance Choice Program.
3. Complete the Home Delivery order form, include your prescription and Copayment and mail it to CVS Caremark. Please allow 14 to 21 days to process your initial order after mailing the
Refilling your mail service prescriptions is easy – you can request a refill by:

- Logging on to caremark.com and requesting your refill online;
- Calling (800) 875-0867 to use the automated refill program;

Note: The automatic refill program is an easy and convenient way to have your prescriptions filled automatically when your current supply is nearing the time it is scheduled to run out. If you sign up, CVS Caremark will send you an email just before they mail out your next refill advising you that your prescription is due to be refilled.

**Generic Drugs**

The brand name of a drug is the product name under which the drug is advertised and sold. Many brand name medications have become well known through advertising. “Generic” drugs are medications sold under generic, often unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid standards for quality, strength and purity as their brand name counterparts.

Generic drugs usually cost less than brand name drugs, so discuss with your doctor whether Generic drugs may be prescribed for you.

Sometimes your doctor may prescribe a medication to be dispensed as written when a Generic drug is available. As part of your prescription drug program, the pharmacist may discuss with your doctor whether a Generic drug might be appropriate for you. Your doctor always makes the final decision on your medication and you may request to keep the original prescription.

In some cases, the Plan requires you to try a Generic drug first or obtain pre-authorization before using a Brand drug where a Generic is available. These requirements are described below under the “Generics First Program” Section.

**Generics First Program**

If the Brand name drug you are prescribed has a Generic equivalent or Generic exact alternative, the Plan may only cover the Generic alternative, unless you or your doctor obtain pre-authorization. For a list of Generic drugs subject to this program, contact Caremark Member Services at (855) 361-8564.

The Generics First program promotes the first line use of clinically appropriate and cost effective generic alternatives within the same therapeutic class. The intention is to try a lower cost medicine as the first step in treating a condition because generic alternatives can cost up to 80 percent less and provide equivalent treatment for many people.

**Generic Equivalents**

The program is made up of select therapeutic classes where a clinically effective, therapeutic equivalent generic medication is required in place of a brand to be covered by the Plan. A therapeutic generic equivalent medication is one that does not share the same active ingredient as its brand counterpart, but provides the same clinically appropriate therapeutic outcome.

If your prescription falls into one of the designated classes with a generic equivalent and you decide to continue with the brand, you must obtain prior authorization from Caremark or you will be responsible for the full cost of the brand prescription.

- For example, one of the targeted classes is High Cholesterol drugs. Therefore, someone who is prescribed Crestor will be required to try a therapeutic generic equivalent such as Atovastatin for their prescription to be covered at all by the Plan, unless they receive prior authorization.
**Generic Exacts**

There are also chemically equivalent generic medications that are made up of the same active ingredient as its brand counterpart. In this situation, the chemical generic equivalent is required in place of the brand in order to receive the maximum benefit under the Plan.

If you elect to continue to take the brand medication when a generic exact is available, you must obtain prior authorization from Caremark or you will be required to pay the difference between the cost of the generic and the cost of the brand in addition to your regular (brand) copay.

- For example, Atovastatin is the direct chemical equivalent to Lipitor as they share the same active ingredient. Therefore, someone who is prescribed Lipitor is required to try a generic exact, such as Atovastatin, to receive the maximum coverage under the Plan. In this case, a participant who wanted to fill Lipitor would be required to pay the Brand co-payment plus the different in cost between Atovastatin and Lipitor, unless they received prior authorization.

**Doctor Instruction and Pre-authorization**

If your prescription is subject to the Generics First program, you and your doctor will be notified by CVS Caremark. If your prescriber feels that you should take the targeted brand medication due to medical necessity, you or your doctor should obtain prior authorization from Caremark by calling toll-free at (877) 203-0003 for more options. You may also contact Caremark for more information about which drug classes are subject to the Generics First program. Your prior authorization request will be subject to the pre-service rules described in the “Claims Information” section.

**Preferred Brand Drugs**

Preferred Brand Drugs are those included on the Caremark Performance Drug List (also referred to as a “formulary”), which is available on the CarMax Benefits website at benefits.carmax.com. Preferred Brand Drugs have a lower copayment for you if you are enrolled in the Select 70 or Premium 80 Plan options. They are generally lower in cost than most Non-Preferred Brand Drugs. The Caremark Performance Drug List is subject to change at any time without notice.

**Non-Preferred Brand Drugs**

Non-Preferred Brand Drugs are those medications which are not generic and not included on the Caremark Performance Drug List. These medications are generally higher in cost.

**Specialty Drugs**

“Specialty” drugs are generally used to treat serious, chronic and complex illnesses and typically have a higher cost and special handling requirements. Please note: if your physician prescribes a Specialty drug, you are required to fill that prescription through the Caremark Specialty Pharmacy for the drug to be covered under the Plan. You will have the opportunity to work with an experienced CVS pharmacy associate who can help you with your questions or with managing any side effects. The Advanced Control Specialty Formulary provides a list of preferred specialty medications, which are more cost-effective than non-preferred brands under the Plan. The Formulary is available on the CarMax Benefits website at benefits.carmax.com and at caremark.com. If you have been prescribed a Specialty drug, please contact Caremark Member Services at (855) 361-8564 and ask to be connected with the Caremark Specialty Pharmacy.

**Prior Authorization**

Your Prescription Drug Program provides coverage for some drugs only if they are prescribed for certain uses. For this reason, some medications must receive prior authorization before they can be filled. If the prescribed medication must be pre-authorized, your pharmacist will inform you. The pharmacist may initiate the review process or you may request your Physician to call a special toll-free phone number that will be supplied by your pharmacist. It typically takes two business days. The patient and Physician will be notified when the review process is completed. If your medication is not approved, you will have to pay the full cost of the prescription to receive it. You also may file an appeal, as described under the “Claims” section. Contact CVS Caremark’s Member Services if you have questions about prior authorization requirements for specific medications.
Drug Utilization Review

When your prescriptions are filled, pharmacists use the health and prescription information on file to consider many important clinical factors including drug selection, dosing, interactions, duration of therapy and allergies. CVS Caremark may contact your Physician to discuss certain clinical factors and benefit management matters. The results of these discussions sometimes lead to changes in your prescription. If your doctor authorizes a change in your prescription, CVS Caremark will send a confirmation letter to you and your doctor. Only the medication authorized by your doctor will be dispensed to you.

Education and Safety

You will receive information about critical topics like drug interactions and possible side effects with every new prescription. By visiting caremark.com, you can access other health-related information, browse health and wellness brochures, get safety tips, find answers to the most commonly asked medication questions, or keep up with timely health issues.

Exclusions

The following prescriptions are not covered under this Plan:

- Vitamins that have over the counter (OTC) equivalents except where covered with a prescription under Preventive Care
- Over-the-counter medications and equivalents, except where covered with a prescription under Preventive Care
- Drugs administered in Hospitals, clinics, or Doctor’s offices (if eligible, such drugs may be covered by Aetna under the “Other Physician Service” provisions of the Plan)
- Drugs not approved by the FDA
Covered Services

Plan services will be covered in accordance with the Plan’s established standards for the service or supply received. Covered Services are the same for all three Plan options. The service or supply must be:

- Medically Necessary,
- Required for the treatment of a medical condition, and
- Recommended and approved by the attending Physician, unless noted otherwise in the treatments and Covered Services listed below.

In addition, certain routine or preventive services and supplies will be covered as specifically described in this Plan. For services and supplies not covered, see the “Exclusions” section.

If you have questions about Covered Services and/or Exclusions, contact Aetna or CVS Caremark Member Services for more information. You and your Physician share responsibility for deciding which services and supplies are received. However, the Plan provides benefits only for Covered Services.

A service or supply may not be Medically Necessary as defined by the Plan if a less intensive or more appropriate diagnostic or treatment alternative could have been used. The recommendation and approval of the attending Physician does not mean the service or supply is Medically Necessary as defined by the Plan.

In addition to the Covered Services described in earlier sections of this SPD, Covered Services include:

**Acupuncture**: Acupuncture treatment by a Doctor of Medicine or a Licensed Acupuncturist (L.Ac.) up to a 30 visit maximum per Plan Year. (Note: Electro-acupuncture is not covered under the Plan).

**Allergy Testing and Treatment**: Services for the diagnosis and treatment of allergies, including tests or treatment materials (injections).

**Ambulatory Surgical Center Services**: Services for covered surgical procedures.

**Anesthetics**: Anesthetics and charges for giving them.

**Applied Behavioral Analysis (ABA) Therapy**: ABA Therapy for the treatment of Autism Spectrum Disorders (ASD).

Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and ABA) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed clinical social worker, as part of a treatment plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Autism Spectrum Disorder is defined in the most recent edition of the DSM.

**Precertification is required prior to ABA Therapy services being rendered**. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

Once approved, ongoing reviews for medical necessity will take place at specific intervals throughout the child’s treatment (intervals vary based on the child’s needs and the target behaviors that are being addressed through therapy).

ABA providers must be independently licensed professionals such as clinical social workers, clinical psychologists or master’s level therapists, or they must be behavior analysts certified by the Behavior Analyst Certification Board. Coverage under the Plan is only when services are performed by Network Providers.

**Bariatric Surgery**: Services are only covered when performed at an Aetna Institute of Excellence™ for Bariatric Surgery. Please contact Aetna at (866) 498-5004 to obtain information on Institutes of Excellence in your area. **All bariatric procedures require precertification prior to services being performed**. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.
These services must be deemed Medically Necessary and all criteria established by Aetna must be met. It is important that you contact Aetna for further details on coverage of these services.

**Basic Imaging:** X-Rays or ultrasound tests performed for diagnosis or treatment. Please refer to the definition of Complex Imaging for other related services. If you have questions about imaging services not listed, please contact Aetna Member Services for more information.

**Chemotherapy:** Chemotherapy administered for the treatment of neoplastic, abnormal tissue formation with chemical agents.

**Chiropractic Care:** Services covered must be performed by a Chiropractor, D.O., or M.D. The Plan covers a maximum of 30 visits per Plan Year, In-Network and Non-Network combined. Coverage includes:

- X-Ray examinations requested or performed by a Chiropractor or in a Chiropractor’s office when the x-rays are of the musculoskeletal system (bones, joints, etc.)
- Charges for office visits when billed with spinal manipulation
- Spinal manipulation

Notes: Physical therapy performed by a Chiropractor is only covered if the Chiropractor is also a licensed physical therapist. Please refer to the definition for Physical Therapy. Supplies when billed by a Chiropractor are not covered.

**Clinical Trials:** Routine patient costs otherwise covered by the Plan that are associated with participation in Phases I-IV of approved clinical trials to treat cancer or other life-threatening conditions, as determined by Aetna and as required by law. These costs will be subject to the Plan’s otherwise applicable Deductibles and limitations and do not include costs of the investigational item, device, or service, items that are provided for data collection, or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**Complex Imaging:** Imaging services including, but not limited to, CT Scans, PET Scans, and MRIs, or Stress Echocardiograms. **Precertification is required for complex imaging services.** Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. The cost for imaging services may vary widely depending on the imaging center, while the services provided generally do not. For example, an MRI performed at a Hospital is generally more expensive than one performed at a stand-alone imaging center. Please contact Aetna to obtain information about cost-effective imaging centers near you. Please refer to the definition of “Basic Imaging” for other related imaging services. If you have questions about imaging services not listed, please contact Aetna Member Services for more information.

**Diabetic Supplies:** Disposable diabetic supplies, available through the Prescription Drug Program, include but are not limited to:

- Test strips
- Syringes
- Insulin pump tubing
- Reservoirs
- Alcohol swabs
- Glucometer
- Lancet device

**Durable Medical Equipment**

Equipment and supplies ordered by a Provider for everyday or extended use, typically in the home, for the treatment of an illness or injury. Coverage for Durable Medical Equipment may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics. Coverage does not include equipment such as whirlpools, sauna baths, massage devices, elevators, communication aids, vision aids, over bed tables, or telephone alert systems.
Experimental or Investigational Treatment:
Charges made for experimental or investigational drugs, devices, treatments or procedures, except as specifically described in “Exclusions,” provided all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/ treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI designated cancer center; and
- You are treated in accordance with protocol.

- Note that coverage may also be provided for Clinical Trial costs, as described above.

Gender Dysphoria: Services related to the treatment of gender dysphoria are covered by the Plan. This includes mental health coverage and treatment leading up to and including gender reassignment surgery. Services related to the treatment of gender dysphoria, including surgery, are subject to the precertification requirements of the Plan. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. Please also refer to the Gender Reassignment Surgery description below for more information.

Gender Reassignment Surgery: Covered expenses include charges in connection with a medically necessary gender reassignment surgery as long as the member has obtained precertification from Aetna. Specifically, covered expenses include:

- Charges made by a Physician for:
  - Performing the surgical procedure; and
  - Pre-operative and post-operative hospital and office visits.
- Charges made by a Hospital for inpatient and outpatient services (including outpatient surgery).
  - Room and board charges in excess of the hospital’s semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.
- Charges made by a Skilled Nursing Facility for inpatient services and supplies.
  - Daily room and board charges over the semi-private rate will not be covered.
- Charges made for the administration of anesthetics.
- Charges for outpatient diagnostic laboratory and x-rays.
- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

Precertification is required for this service. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. No payment will be made for any covered expenses under this benefit unless they have been precertified by Aetna.

Note: Consistent with the Plan’s exclusion of cosmetic services, coverage for Transgender Reassignment Surgery does not include the following services: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid condroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminimization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.
**Habilitative Services:** Health care services that help you keep, learn, or improve skills and functioning for daily living (i.e., therapy for a child who is unable to walk or talk at the expected age).

**Health Care Providers’ Services:** Services of a licensed or certified Health Care Provider acting within the scope of that license or certification. Covered Services for allied and ancillary Health Care Providers are payable on the same basis (In-Network and Non-Network) as Covered Services given by a Physician.

**Home Health Care:** Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan and provided that you are:
- Transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay; or
- Homebound.

*Precertification is required for home health care.* Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

Covered expenses include:
- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time.
  - Each visit (of up to four (4) hours) provided by a Nurse or Therapist counts as one visit.
  - An exception to the above applies when Home Health Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time inpatient or when care is needed to transition from a Hospital or Skilled Nursing Facility to home care. In those cases, covered expenses include up to 12 hours of continuous care by a Nurse per day.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a Physician and directly related to an active treatment plan of care established by the Physician and all of the following are met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a hospital or Residential Treatment Facility, or receiving outpatient services outside of the home.
  - You are homebound because of illness or injury.
  - The services provided are not primarily for comfort, convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.
  - Each hour provided by a behavioral health provider counts as one visit.
- *Note:* Home Health Care coverage does not include “Custodial Care” (as defined in the Exclusions section), even if Home Health Care is provided by a nursing professional and a family member or other caretakers cannot provide the necessary non-skilled care.

**Hospice Care:** Services in an inpatient Hospice facility or in the patient’s home. *Precertification is required for Hospice care.* Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. The Physician must certify that the patient is terminally ill with 12 months or less to live. Benefits include:
- Room and board expenses charged by the Hospice.
- Other services and supplies, including counseling.
- Part-time nursing care by or supervised by a Registered Nurse (RN).
- Home health care services as shown under “Home Health Care.” Prior Hospital confinement is not required.
Services for family members covered under Hospice care include counseling given by a licensed social worker or a licensed pastoral counselor.

A “Hospice” is defined as an agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must:

- be approved under any required state or governmental Certificate of Need;
- be established and operated in accordance with any applicable state laws; and
- meet the criteria established by Aetna for a Hospice.

**Hospital Services – Room and Board:** Benefits include:

- Charges for a ward, a semi-private room or an intensive care unit. The full amount of Recognized Charges will be counted as Covered Expenses.
- If admitted to a private room, charges up to the Hospital’s regular daily charge for a semi-private room will be counted as Covered Expenses.

**Hospital services require precertification.** Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

A “Hospital” is defined as an institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient’s expense and:

- Is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals;
- Is approved by Medicare as a Hospital; and
- Meets the criteria established by Aetna as a Hospital.

**Maternity:** If you or your covered dependent is pregnant, guidelines provided under the Newborns’ and Mothers’ Health Protection Act of 1996 stipulate that a mother and her newborn may remain in the Hospital for 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the law does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

If a longer inpatient stay is required for the mother or newborn, precertification is required for the additional stay. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. For purposes of this section, the term “attending provider” has the meaning required under the Newborns’ and Mothers’ Health Protection Act of 1996 and the regulations thereunder. An “attending provider” does not include a group health plan, Hospital, managed care organization, or other issuer.

Refer to the Preventive Care section of this booklet for information on the coverage for Prenatal Preventive Care and Breastfeeding Supplies.

Other covered Maternity services include:

- **Birthing Centers.** “Birthing centers” are defined as a specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests:
  - Is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; and
  - Meets the criteria established by Aetna as a Birthing Center.
- **Nurse-Midwife.** A Nurse-Midwife is defined as a person who is licensed or certified to practice as a Nurse-Midwife, is licensed by the board of nursing as a Registered Nurse (RN), and has completed a program approved by the state for the preparation of Nurse-Midwives.

**Medical Supplies:** Covered expenses include:

- Blood or blood plasma only if not donated or replaced
- Durable Medical Equipment (such as iron lung, prosthetics, rental of dialysis machines, resuscitators, Hospital-type beds, traction equipment, wheelchairs and walkers)
- One (1) pair of eyeglasses or contact lenses required to replace human lenses lost due to cataract surgery
- Orthopedic Braces
- Oxygen and charges for giving it, including rental of required equipment
• Rental of a device to help breathing when paralyzed
• Surgical Supplies required during a surgical procedure

**Mental Health Services:** See the “Mental Health & Substance Abuse” section above for more information regarding covered mental health services.

**Nursing Services:** This includes services of a trained nurse or services of a licensed or certified Nurse-Midwife or Nurse-Practitioner acting within the scope of that license or certification. Services do not have to be recommended and approved by a Physician. Covered Services given by a licensed or certified Nurse-Midwife or Nurse-Practitioner are payable on the same basis as Covered Services given by a Physician.

**Nutrition Services:** These services are limited to those requiring medical management and skilled administration and maintenance.

**Occupational Therapy:** Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function. Occupational therapy is a Therapy Service as defined below. The Plan covers a maximum of 60 visits per Plan Year for Rehabilitative and Habilitative Services.

**Oral Surgery:**
• Charges related to accidental injury, by external force, to natural teeth (within 12 months of date of accident)
• Necessary facility charges for dental oral surgery
• Orthognathic Surgery
• Charges for the surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ) (Appliances are not covered)
• **Precertification is required for these services.** Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

**Organ/Tissue Transplant:** An additional program available at Aetna is the National Medical Excellence/Institutes of Excellence Transplant Program. This program selectively identifies Institutes of Excellence for Plan Participants. These Institutes of Excellence have experience with certain high-risk, high-cost, transplant-related medical and surgical procedures. The use of an Institutes of Excellence Facility as designated by Aetna is voluntary, but travel and donor search benefits are provided only if an Institute of Excellence Facility is used and Aetna manages the care.

**Precertification is required for the related Hospital stay.** Please refer to the “Precertification of Services” and “Precertification Penalties” of this document for additional information.

Benefits are payable for charges for covered family members in connection with the organ/tissue transplants listed below. If the procedure is not performed at an Institutes of Excellence Facility, benefits are payable at either the In-Network or Non-Network benefit level, whichever is applicable.

Benefits are payable for charges made for the following organ/tissue transplants:
• Bone marrow/stem cell transplants
• Heart, Lung or Heart/Lung transplants
• Kidney or Pancreas transplants
• Simultaneous Pancreas Kidney (SPK)
• Liver transplants
• Intestine transplants
• Multiple organs replaced during one transplant surgery
• Tandem transplants (Stem Cell)
• Sequential transplants
• Re-transplant or same organ type within 180 days of the first transplant
• Any other single organ transplant, unless otherwise excluded under the Plan

For organ/tissue transplants, the Plan covers the following:
• Charges made by a physical or transplant team
• Charges made by a hospital, outpatient facility, or physical for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program
• Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech, and occupational therapy; bio-medicals and immunosuppressants; Home Health Care, and home infusion services, subject to certain limitations
• Charges for activating the donor search process with national registries
• Compatibility testing of prospective organ donors who are immediate family members (biological parents, siblings, or children)
• Inpatient and outpatient expenses directly related to a transplant

If an Institute of Excellence Facility is used, charges made in connection with the search for bone marrow from a donor who is not biologically related to the patient will be covered. However, there is a maximum benefit of $15,000 for all charges made in connection with the search.

When significant travel is required to use an Institutes of Excellence Facility, you may be eligible for travel and lodging allowances according to Aetna’s standard internal policies and procedures. Please contact Aetna Medical Management for more information.

**Physical Therapy:** Physical therapy is the treatment of disorders or injuries using physical methods or agents, such as exercise, massage, heat treatment, or ultrasound treatment. Physical therapy is appropriate for treatment of muscle weakness, limited range of motion, neuromuscular conditions, musculoskeletal conditions, joint edema, post-surgical conditions, muscle stimulation, to promote healing, improvement of function, and for analgesic purposes. Physical therapy must be performed by a licensed physical therapist or medical doctor. Physical therapy is not covered under the Plan when performed by a Chiropractor who is not also a licensed physical therapist. Physical therapy is a Therapy Service as defined below. The Plan covers a maximum of 60 visits per Plan Year for Rehabilitative and Habilitative Services.

**Podiatrists:** Covered Services (non-routine) from certified podiatrists acting within the scope of their license or certification. Please refer to the “Exclusions” list for related services that are not covered.

**Pre-Admission Tests:** Tests performed prior to Hospital confinement.

**Preventive Care:** See the “Preventive Care” section above for more information regarding preventive services covered for adults, women, and children.

**Radiation Therapy:** Radiation therapy is the treatment of cancer by x-rays or other sources of radioactivity with both producing ionizing radiation. *Radiation therapy requires precertification.* Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

**Rehabilitative Services:** Rehabilitative Services refers to the combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

**Skilled Nursing Facility Care:** Room and board and other services and supplies. Covered Expenses for room and board will be the facility’s regular daily charge for a semi-private room. *Precertification is required for any confinement.* Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document. A Skilled Nursing Facility is covered by this Plan if approved by Medicare as such. If not approved by Medicare, it must meet the criteria established by Aetna for a Skilled Nursing Facility.

**Speech Therapy:** Speech therapy is the treatment of communication disabilities and swallowing disorders. Speech therapy is covered when used as part of the treatment for lost functionality as a result of injury or illness or as a result of developmental delay. To be eligible for coverage, there should be a definite event or disease from which there needs to be a recovery or rehabilitation. Speech therapy is a Therapy Service as defined below. The Plan covers a maximum of 60 visits per Plan Year for Rehabilitative and Habilitative Services.

**Substance Abuse Treatment:** See the “Mental Health & Substance Abuse” section above for more information regarding covered substance abuse treatment services.
Therapy Services: “Therapy Service” includes Physical, Occupational and Speech Therapy. Therapy is the application of clinical skills and/or services that attempt to improve function to treat a disease or pathological condition or as a result of developmental delay. Please refer to the individual definitions for each form of Therapy. Therapy Service visits in excess of the limits described may be eligible for coverage under the Plan; however, such services must be Medically Necessary and are subject to the pre-approval of Aetna’s Medical Management group prior to services being rendered in order for benefits to be paid. You may contact Aetna’s Medical Management group at (866) 498-5004.

Transportation, Emergency Medical Care and/or Required Medical Services:

- Professional ambulance to and from a Hospital.
- Professional ambulance to and from a medical facility.
- If a professional ambulance service is used in a non-emergency situation, precertification is required. Please refer to the “Precertification of Services” and “Precertification Penalties” sections of this document.

Women’s Health and Cancer Rights Act

The Women’s Health and Cancer Rights Act of 1998 requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Coverage for these services is subject to annual Deductibles and Coinsurance provisions just like other medical and surgical services covered under the Plan.
Exclusions

In addition to any exclusions or limitations already described, the Plan DOES NOT cover services for:

**Cosmetic Services:**
- Care, services or drugs solely for cosmetic purposes, surgery or treatment designed to improve the appearance of an individual by surgical alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasant or unsightly and which is not for the improvement of physiological functions (except as required by law under the Women’s Health & Cancer Rights Act – see notice on prior page)
- Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid condroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), skin resurfacing, chin implants, nose implants, or lip reduction
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness
- Drugs for cosmetic use or weight loss

**Court Orders:**
Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services

**Custodial Care:**
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care:
- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications
- Care of stable tracheostomy (including intermittent suctioning)
- Care of stable colostomy/ileostomy
- Care of stable gastrostomy/ jejunostomy/ nasogastric tube (intermittent or continuous) feedings;
- Care of stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting Participant;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with daily living activities, such as walking, grooming, bathing, dressing, getting in and out of bed, toileting, eating and preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

**Dental Care:**
- Appliances and adjustments to appliances for treatment of Temporomandibular Joint Disorder (TMJ)
- Services of a Dentist or Physician for care and treatment of the teeth and gums except for the services described under the heading “Oral Surgery” in the “Covered Services” section of this document

**Education:**
Educational services are:
- Any service or supply for education, training, or retraining services or testing. This includes special education, remedial education, wilderness program, job training and job hardening program; and
- Services provided by a school district, except where required by law.
Experimental Services:
Health services and associated expenses incurred for services and supplies for experimental, investigational or unproven services, treatments, devices, and pharmacological regimens, except as specifically described in “Covered Services.” This includes medical, surgical, diagnostic, psychiatric, Substance Abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Plan makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that an experimental, investigative or unproven service is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigative or unproven for the treatment of that particular condition.

Hearing Aid and Diagnostic Services: Hearing Aids or examination for the purpose of prescribing, fitting or changing Hearing Aids. (A Hearing Aid discount program is available to all Aetna members. Please refer to the aetna.com website for more information.)

Maintenance Care:
Care made up of services and supplies that;

- Are furnished mainly to maintain, rather than to improve, a level of physical or mental function; and
- Providing a surrounding free from exposures that can worsen the person’s physical or mental condition.

Non-Medically Necessary Services: Services or supplies determined not to be Medically Necessary or consistent with the diagnosis, including any confinement, treatment, service or supply given in connection with a service or supply which is not Medically Necessary

Medications or Prescriptions:
- Prescription refills in excess of the number specified by the Physician, limits for days’ supply or any refill dispensed after one year from the Physician’s original prescription
- Drugs not approved by the FDA for the treatment of the member’s health condition
- Herbal medicine
- Non-legend drugs, except as specified
- Legend multivitamins and supplements with over-the-counter counterparts and hemopathic agents used to treat anemia
- Excluded legend drugs such as: topical minoxidil, cosmetic drugs, any covered drug provided by a Hospital to a covered individual confined therein; any kind of device or apparatus, regardless of therapeutic effect (e.g., hypodermic needles and syringes, except for insulin or other injectibles, support garments, similar items)
- Holistic or homeopathic care, including drugs and environmental or ecological medicine

Podiatry: Services for callus, corn paring or excision, toenail trimming and treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches, flat or pronated foot, pain or cramping of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot.

Pregnancy/Reproduction:
- Charges for procedures which facilitate a pregnancy, but do not treat the cause of infertility (e.g., in-vitro fertilization or artificial insemination)
- Services for reversal of voluntary surgical sterilization
Vision:
- Radial Keratotomy or other surgical procedures to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with or related to the surgery
- Eye glasses, contact lenses, and routine eye (refractive) exams, except as specifically provided in "Covered Services."

Other Services:
- Services of a person who is a member of the Participant’s immediate family or who resides in their home
- Services given by volunteers or persons who do not normally charge for their services
- Services given by a licensed pastoral counselor to a member of his or her congregation in the course of his or her normal duties as a pastor or minister
- Administrative fees associated with whole blood donation for which no payment is required
- Any covered service for which payment to the provider is not required
- Expenses not legally required to be paid
- Amounts in excess of the Recognized Charge for a Covered Service
- Care by interns, residents or Practitioners who are employees of Hospitals, laboratories or other institutions.
- Services rendered in conjunction with those of an attending Physician whose services are not covered
- Services, exams or tests not needed to treat accidental injury, sickness or pregnancy, except as specifically provided by name in the Plan
- Services or supplies not specifically listed as Covered Services
- Telephone consultations, except where covered under Teladoc services
- Non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan’s Test) treatment of non-specific candida sensitivity and urine auto-injections
- Over-the-counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments, except as required by law and covered under Preventive Care
- Annual or other charges to be in a physician’s practice
- Charges to have preferred access to a physician’s services
- Cancelled or missed appointment charges or charges to complete claim forms
- Health club memberships, figure salons, weight reduction clubs, programs or classes
- Personal hygiene and convenience items including, but not limited to, TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs
- Covered services for which payment is made or available through Workers’ Compensation or a similar law
- Injury which happens during work at any job for pay or profit
- Injury or sickness caused by participation in declared or undeclared war, riot, civil disobedience or international armed conflict

Financial Sanctions Exclusions
If any benefit provided by this Plan violates or will violate any economic or trade sanctions set by the Office of Foreign Assets Control ("OFAC") of the US Department of the Treasury, the coverage is immediately considered invalid. For example, the Plan will not make payments for health care or other claims or services if it violates a U.S. financial sanction regulation, including sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written OFAC license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.
Coordination of Benefits

To prevent the duplication of benefits, Aetna will coordinate benefits under this Plan with similar benefits under other plans in which the covered Associate or any dependents participate. Benefits from this Plan will be determined so that when they are combined with benefits from any other plans they will not exceed that which would have been paid under this Plan if no other coverage existed. Other plans include, but are not limited to:

- Another employer group health plan, collectively bargained plan, or individual insurance coverage, where permitted by law.
- A No-Fault Automobile Insurance Law.
- A government or tax-supported program, including Medicare or Tricare, except as otherwise provided under this Plan (excluding Medicaid).
- Any Workers’ Compensation coverage.

Establishing Which Plan Is Primary

To understand how coordination of benefits works, it is first necessary to determine which plan pays benefits first—that is, which plan is “primary” and which is “secondary.”

As a general matter, a plan that has no coordination of benefits provision will be primary to a plan that has such a provision. If all plans have a coordinating provision, the following will apply:

- The plan that covers a person as an employee, retiree or survivor will be primary to a plan that covers the same person as a dependent.
- Where both plans cover a person as a dependent, the plan of the participant whose birthday occurs earlier in the calendar year is primary.
- When the parents of a dependent child are divorced or separated and there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary. If there is no court decree establishing financial responsibility:
  - The plan of the parent who has custody and who has not remarried is primary.
  - When the parent with custody has remarried, that parent’s plan and the stepparent’s plan are primary to this Plan.
- If one plan covers an associate (or his or her dependents) as an active employee, and another covers the associate (or his or her dependents) as a retiree or laid-off employee, the plan covering the associate (or his or her dependents) as an active employee will be primary.
- If an individual (or his or her dependent) is receiving continuation coverage under this Plan and also is covered as an employee (or dependent of an employee) under another plan, the other plan is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule does not apply.
- If the above rules do not establish which plan is primary or secondary, the plan that has covered the individual longest will be primary.

How Coordination Works

If this Plan is primary, it will pay benefits first. Benefits under this Plan will not be reduced due to benefits payable under other plans.

If this Plan is secondary, benefits under this Plan will be reduced by benefits available under other plans that are primary to this Plan. These rules apply whether or not a claim is made under the other plan.

Aetna will send a letter to dependents covered under this Plan periodically to determine if the dependents have other health coverage. Claims for the subject dependent will not be paid until Aetna receives updated information from you or your dependents.
More detailed rules used to determine which plan is primary and how benefits are coordinated are set forth in the Master Welfare Plan.

**Medicare Secondary Payer Rules: Individuals Age 65 or Older**

The Plan will pay primary, or before Medicare, if an Associate and/or their Spouse is eligible for Medicare due to age and the Associate is actively working for the Company in a “current employment status” as defined by federal law and determined by the Company.

Under this rule, all benefits to which the covered Associate and his/her Spouse are entitled under this Plan will be paid as primary, or before and without regard to any benefits available under Medicare, unless they waive coverage under this Plan. Medicare will then pay any amounts not paid by the Plan, up to the Medicare limits.

**Medicare Secondary Payer Rules: Other Medicare Beneficiaries**

Where an Associate is no longer working (for example, is retired) Medicare generally will pay primary, or before the Plan pays. There may be special rules when an individual is eligible for Medicare due to disability or end stage renal disease (ESRD). You should consult Aetna on your particular circumstances or review information at [www.medicare.gov](http://www.medicare.gov).

Where Medicare is primary, it will pay before the Plan pays, and the Plan may pay the difference, but only if a service otherwise is covered under the Plan and subject to the Deductibles and other cost sharing required by the Plan. In addition, the Plan only will pay amounts left over as if both Medicare Part A (Hospital) and Medicare Part B (Medical Care Plan) had already paid, regardless of whether you or your dependent is enrolled in Part A and B. Even if a person does not have Part B, the amount normally covered under Part B will be subtracted from the amount this Plan would normally pay. So, you should think carefully when deciding whether to enroll in Parts A and B.

Generally, you should enroll in Medicare as soon as you are eligible. When you enroll, Medicare will pay some of the same Hospital and medical expenses covered under this Plan. You should submit all claims to Medicare for payment. Medicare will pay its benefits first, then this Plan will pay benefits. Aetna will determine the amount this Plan would normally pay. You will never be paid more for the same expenses under both this Plan and Medicare than this Plan would have paid alone.

“Amount payable under Medicare” includes any benefits not provided under Medicare to the extent payment under Medicare is reduced because of benefits available under another employer’s plan. This applies when those benefits are determined to be primary to Medicare as a result of federal law.

The covered Associate may be the person eligible under Medicare. This will not affect the coverage then in effect for his/her dependents. Dependent coverage will continue until the earlier of the following:

- The dependent becomes eligible for Medicare.
- The dependent’s coverage stops as shown in the section below titled “When Coverage Ends.”

Please refer to the Medicare Part D Notice included as part of this document for important information about prescription coverage for Medicare-eligible individuals.
The Plan’s Right to Recover Overpayment

Payments are made in accordance with the provisions of this Summary Plan Description and the Master Welfare Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or Aetna) will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary or dependent. Failure to comply with this request will entitle the Plan to withhold benefits due a participant, beneficiary or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan’s behalf if the Plan's collection effort is not successful.

In addition, if the overpayment is made to a provider, the Plan (or Aetna) may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current and/or future claims with the provider on behalf of any participant, beneficiary, or dependent in the Plan. If a provider to whom an overpayment was made has patients who are participants in other health and welfare plans administered by Aetna, Aetna may reduce payments otherwise owed to the provider from such other health plans by the amount of the overpayment.
Right to Audit

The Plan has the right to audit your claims and your dependent's claims, including claims of medical providers. The Plan (or Aetna) may reduce or deny benefits for otherwise covered services for all current and/or future claims with a provider made on behalf of you or your dependent, or a participant in any other health and welfare plan administered by Aetna on the results of an audit. The Plan may also reduce or deny benefits for otherwise covered services for all current and/or future claims filed by you or a dependent based on the results of an audit.
Subrogation/Reimbursement

Reimbursement to the Plan if You Recover Payment for an Injury or Illness

This section applies if you or your legal representative, estate, or heirs recover money or other property for an injury, sickness, or other condition, including a recovery from any insurance carrier.

If your claim results from an accident, injury, or other condition that may be the fault of another party, the Plan will not cover the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded from the Plan. The Plan may, however, advance funds to cover such treatment, in which case you must promptly convey moneys or other property from any settlement, arbitration award, verdict, insurance payment, or other recovery from any party to the Plan for the amount of benefits the Plan has provided, regardless of whether: (i) you have been fully compensated or made whole for your loss; (ii) liability for payment is admitted by the you or any other party; or (iii) the recovery is specified as a recovery for medical expenses incurred. If benefits are advanced, you will be considered the constructive trustee over these funds, and failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan.

If a recovery is made, the Plan shall have first priority in payment over you or any other party to receive reimbursement of the benefits advanced on your behalf. The Plan has the right to 100% reimbursement in a lump sum. This reimbursement shall be from any recovery made by you, and includes, but is not limited to: uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners or otherwise); workers’ compensation settlement, compromises or awards; other group insurance (including student plans); other individual insurance to the extent not prohibited by state law; and direct recoveries from liable parties.

You must acknowledge that the Plan shall have first priority against the proceeds of any such settlement, arbitration award, verdict, or any other amounts you receive and assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement. At the request of the Plan, you must sign and deliver, any documents needed to protect the Plan’s priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan, you acknowledge that any proceeds of settlement or judgment, including a claim to such proceeds held by another person, are being held for the benefit of the Plan.

You must cooperate with the Plan and must sign and deliver any documents that the Plan or its agents reasonably request to protect the Plan’s right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan in fully recovering the reasonable value of the benefits provided. You shall not take any action that prejudices the Plan’s rights of reimbursement. You consent to the right of the Plan to impress an equitable lien or constructive trust on any recovery to enforce the Plan’s rights under this section and/or to set off from any future benefits otherwise payable under the Plan the value of moneys and other benefits advanced to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. You shall not incur any expenses on behalf of the Plan in pursuit of the Plan’s rights. Specifically, no court costs or attorney’s fees may be deducted from the Plan’s recovery without the express written consent of the Plan. Any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” or other equitable defenses shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid, without regard to any claim or fault on your part, whether under comparative negligence or otherwise.
Plan's Right to Subrogation

This section applies if another party is, or may be considered, liable for your injury, sickness, or other condition (including insurance carriers who are financially liable).

The Plan will not cover either the reasonable value of the services to treat an injury, sickness, or other condition where another party may be considered liable. These benefits are specifically excluded. The Plan may, however, advance moneys or provide benefits for such an injury, sickness, or other condition, and, if so, in consideration for the advancement of benefits, the Plan is subrogated to all of the rights you may have against any party liable for your injury, sickness, or other condition (or liable for payment for such liability), including any insurance carrier, in the amount of moneys or the value of other benefits advanced or provided by the Plan to you.

The Plan may assert this right independently. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion. If such moneys are advanced, you shall be considered the constructive trustee over these funds, and failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. The Plan has the right to 100% reimbursement in a lump sum.

You are obligated to cooperate with the Plan and its agents to protect the Plan’s subrogation rights. Your obligations include, but are not limited to, providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to enforce the Plan’s subrogation right, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations relating to your injury, sickness, or other condition, you must not prejudice, in any way, the subrogation rights of the Plan. If you fail to cooperate, including executing any documents required, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the money and value of other benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation shall be borne solely by you. Specifically, your court costs or attorney’s fees shall not be deducted from the Plan’s recovery without the express written consent of the Plan. Any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” or other equitable defenses shall not defeat this right.

Notification & Deemed Acceptance

You specifically agree to notify the Plan Administrator promptly in writing whenever: (i) amounts are paid that may be subject to these rules; or (ii) you or another party initiates an action for recovery against a third party for acts or omissions that caused an injury, sickness or other condition for which benefits have been or may be paid under this Plan.

Acceptance of coverage under the Plan is deemed acceptance of the terms and conditions of the Plan, including the reimbursement, subrogation and notification provisions of this section, and the exhaustion, limitations period, and exclusive forum provisions described in this SPD and the Master Welfare Plan document.
Benefits May Not Be Assigned

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.
Claims Information

This section explains how to file claims for benefits and how to appeal denied claims. The following information applies only to claims for benefits under the Plan. You may have claims or disputes that are not claims for benefits, such as a claim related solely to your enrollment or eligibility status (including COBRA eligibility). The procedures applicable to these other claims are set forth below under the heading “Appealing an Enrollment or Eligibility Status Decision.”

Any reference to “you” in this section includes you and your Authorized Representative. An “Authorized Representative” is a person you authorize, in writing, to act on your behalf.

A general inquiry as to whether a service is covered is not considered a claim for benefits. You must file a claim for benefits as described below.

Medical Claims with Aetna

Providers who participate in the Aetna Network have agreed to submit claims directly to Aetna. Therefore, if you use Network Hospitals and Physicians, you do not have to file claims for their services. In addition, many Non-Network Hospitals and Physicians will also file claims if you give them the information on your ID card. If the provider requests a claim form, that form can be obtained by calling Aetna at (866) 498-5004.

To File a Claim:

1. Complete the Aetna claim form. A separate claim form must be completed for claims being submitted for each covered person. For medical claims, the provider must complete the front portion of the form.
2. Attach all itemized bills to the claim form.
3. Make copies of all bills and claim forms. It is important to keep records for each covered family member.
4. Mail the original claim form and itemized bills to:
   Aetna
   P.O. Box 981106
   El Paso, TX 79998-1106

File claims as soon as possible. Only claims submitted within fifteen (15) months following the date of service will be accepted.

If your claim is denied in whole or in part, you will receive a written notice of denial from Aetna (unless the claim is an Urgent Care Claim, as defined below, in which case notice may be delivered orally). The notice will explain the reason for the denial and the appeal procedures available under the Plan. A denied claim is referred to in this section as an “Adverse Benefit Determination.” An Adverse Benefit Determination may include a denial due to a rescission (retroactive termination) of coverage.

When Claims Are Paid

There are three categories of claims for benefits. Each one has a specific timetable for approval and payment or denial of the claim. The three categories of claims for benefits are urgent care claims, pre-service claims, and post-service claims.

- An Urgent Care Claim is a claim where failing to make a determination quickly could seriously jeopardize a claimant’s life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A Physician with knowledge of the claimant’s medical condition may determine if a claim is an Urgent Care claim and may act as the claimant’s Authorized Representative.
- A Pre-Service Claim is a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment.
- A Post-Service Claim is a request for payment for covered services you have already received or for which you are not required to obtain advance approval or pre-certification.
Urgent Care Claim
If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that your claim is an Urgent Care Claim, you will be notified of the decision on your claim, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If Aetna needs additional information to decide your claim, you will be notified of the information necessary to complete your claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Pre-Service Claim
If the Plan requires advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision on your claim within a reasonable period of time appropriate to the circumstances, but not later than 15 days after Aetna’s receipt of the Pre-Service Claim.

Post-Service Claim
All other claims are considered Post-Service Claims. You will be notified of the decision on such claims within a reasonable time, but not later than 30 days after Aetna’s receipt of the claim.

For either a Pre-Service or a Post-Service claim these time periods may be extended up to an additional 15 days due to circumstances outside Aetna’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, these time periods may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). If Aetna is unable to obtain the necessary claim information within the 45-day timeframe, the claim will be decided based on the information available and may be denied.

Ongoing Course of Treatment
If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

How Claims Are Paid
If your claim is approved and you assigned benefits to or received services from a Network Provider, the Plan will make payment directly to that provider. Benefits for Non-Network Covered Services will be reimbursed directly to you. You are responsible for payment to Non-Network Providers.

Explanation of Benefits (EOB) / Notice of Adverse Benefit Determination
If the Plan denied your claim or appeal, you will receive an Explanation of Benefits (EOB) that explains, step-by-step, how your claim was processed. The EOB will show the amount of the charge, the amount covered, the amount applied to the Deductible, the Plan Coinsurance percentage, the Network adjustment and the patient responsibility. EOBs are available online when you log into the aetna.com website or you may request a paper copy free of charge by contacting Aetna Member Services.
If your claim is denied, the EOB will include the following information:

- Specific reason for adverse determination;

- Information sufficient to identify claim involved, including date of service, health care provider, and claim amount (if applicable);

- Denial code and corresponding meaning;

- Statement describing availability, upon request, of diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;

- Description of plan or issuer's standard, if any, used in denying claim;

- Reference to specific plan provision on which determination based;

- Description of any additional material or information necessary to perfect claim and explanation why material is necessary;

- Description of review procedures and time limits, including, if urgent claim, description of expedited review process;

- Statement of claimant's right to bring civil action under ERISA § 502(a) following adverse determination on review;

- Any specific internal rule, guideline, protocol, or similar criterion relied upon in making adverse determination, or statement that rule was relied upon and copy is available free of charge upon request;

- If based on medical necessity or experimental treatment limit or exclusion, explanation of scientific or clinical judgment for determination applying plan terms to claimant's medical circumstances, or statement that such explanation will be provided free of charge upon request;

- Statement claimant entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to claim; and

- Statement describing any voluntary appeal procedures offered by plan and claimant's right to obtain information about procedures.
Prescription Drug Claims with CVS Caremark

Prescription Drug Claims will be paid in accordance with this Plan and with CVS Caremark’s established standards for the prescription medications received. When the CVS Caremark card is used at a participating pharmacy, there are no claims to file. If the card is not used, you disagree with the amount of coverage, or a non-participating pharmacy is used, you must file a claim form with CVS Caremark. Claims must be filed within twelve (12) months following the end of the Plan Year. Call CVS Caremark’s Member Services at (855) 361-8564 or log into your account at caremark.com to obtain a claim form.

To File a Claim:

- Read the instructions and complete the form.
- Attach the receipts.
- Send the completed form to:

  CVS Caremark Claims Department
  P.O. Box 52136
  Phoenix AZ 85072-2136

Claims will be decided in accordance with the timeframes set out above for Medical Claims, depending on the type of claim.

How to Appeal a Denied Claim for Benefits

If your claim for benefits is denied, you may appeal that denial. If your first appeal is denied, you may file a second appeal. If both appeals are denied, you generally may: (i) seek an additional External Review by an independent review organization if your claim involves medical judgment; (ii) file a Voluntary Appeal directly to the Plan Administrator (the Benefits Administrative Committee of CarMax); or (iii) file a lawsuit under Section 502(a) of ERISA. Each of these options is discussed below.

First Level Appeal

You will have 180 days following delivery of an Adverse Benefit Determination to file a first-level appeal. If you fail to appeal your claim by this deadline, you will be deemed to have waived your right to request a review of the denial of your claim.

When requesting a First Level Appeal of all claims except prescription drug claims, send the written request to:

  Aetna
  P.O. Box 981107
  El Paso TX 79998-1107

When requesting a First Level Appeal of prescription drug claims, send the written request to:

  CVS Caremark
  Appeals Department
  MC 109
  P.O. Box 52084
  Phoenix AZ 85072-2084

  Fax Number 1-866-443-1172

Your request should reference CarMax and include your name, your member ID, or other identifying information shown on the front of the Explanation of Benefits form. You may submit written comments, documents, records and other information relating to your claim, whether or not they were submitted in connection with the initial claim. You may also present evidence and testimony. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request, as well as copies of all documents, records and other information relevant to the claim. Certain information will be provided to you free of charge regardless of whether you request it, including any new
or additional evidence that is considered, relied on or generated by, or at the direction of, Aetna or CVS Caremark in connection with your claim.

You will be notified of the decision not later than 15 days (for Pre-Service Claims) or 30 days (for Post-Service Claims) after the appeal is received.

If your claim involves urgent care, you may initiate an expedited appeal by calling the telephone number included in your notice of denial or, for all claims except prescription drug claims, by calling Aetna’s Member Services. The telephone number for Aetna’s Member Services is on your ID card. You may appeal urgent care claims in writing or orally. All information, including the appeal decision, will be communicated between you and Aetna or CVS Caremark by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

**Second-Level Appeal**

If you are dissatisfied with the decision on your first-level appeal, you may file a second-level appeal. You must file this appeal within 60 days of delivery of your first-level appeal decision. If you fail to appeal your claim by this deadline, you will be deemed to have waived your right to request a review of the denial of your claim.

When requesting a Second-Level Appeal of all claims except prescription drug claims, send the written request to:

Aetna  
P.O. Box 981107  
El Paso TX 79998-1107

When requesting a Second-Level Appeal of prescription drug claims, send the written request to:

CVS Caremark  
Appeals Department  
MC 109  
P.O. Box 52084  
Phoenix AZ 85072-2084

Fax Number 1-866-443-1172

You will be notified of the decision not later than 36 hours (for urgent care claims), 15 days (for Pre-Service claims) or 30 days (for Post-Service claims) after the appeal is received.

You will receive a written notice of the decision on your Second-Level Appeal. The denial of a second-level appeal is referred to in this section as a “Final Internal Adverse Benefit Determination.”

**Notice of Adverse Benefit Determination**

If your appeal is denied at either level, you will receive a notice that includes the following information:

- Specific reason for adverse determination;
- Information sufficient to identify claim involved, including date of service, health care provider, and claim amount (if applicable);
- Denial code and corresponding meaning;
- Statement describing availability, upon request, of diagnosis code and its corresponding meaning and treatment code and its corresponding meaning;
- Description of plan or issuer's standard, if any, used in denying claim;
- Specific reason for adverse determination;
Health Claims – External Review and Voluntary Appeals

If you are dissatisfied with a Final Internal Adverse Benefit Determination from Aetna, you have three options. First, in certain circumstances you may be allowed to pursue an appeal to an independent review organization (referred to below as “External Review”). Second, you may pursue a voluntary appeal directly to the Plan Administrator (the Benefits Administrative Committee of CarMax). Finally, you have the right to bring a lawsuit under Section 502(a) of ERISA, if applicable.

Each of these options is described below. You must complete a first and second-level appeal to Aetna before you can pursue any of these voluntary options (unless you qualify for urgent external review, as described below). This is referred to as having “exhausted” your administrative remedies.

The filing of a voluntary appeal will have no effect on your rights to any other benefits under the Plan. If you choose not to file a voluntary appeal, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

If you are dissatisfied with a Final Internal Adverse Benefit Determination from the Plan Administrator, you have the right to bring a lawsuit under Section 502(a) of ERISA, if applicable.

External Review

An “External Review” is a review of a Final Internal Adverse Benefit Determination by an independent External Review Organization (“ERO”). External Review is available in the case of a rescission of coverage or an adverse benefit determination that involves medical judgment.

The notice of Final Internal Adverse Benefit Determination that you receive from Aetna or CVS Caremark will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

If you wish to pursue External Review, you must submit the Request for External Review Form to Aetna or CVS Caremark within four months of the date you received the Final Internal Adverse Benefit Determination notice. You must include a copy of the notice and all other information supporting your request. If Aetna determines that you are eligible for External Review, you will be informed in writing of the steps necessary to request such a review.

An ERO will refer your case for review by a neutral, independent clinical reviewer with appropriate expertise. The decision of this independent reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.
Preliminary Review

Within 5 business days following the date of receipt of the request for External Review, Aetna or CVS Caremark must provide a preliminary review determining whether: (i) you were covered under the Plan at the time the service was requested or provided; (ii) the determination relates to medical judgment or a rescission of coverage; (iii) you have exhausted the internal appeals process; and (iv) you have provided all paperwork necessary to complete the External Review.

Within one business day after completion of the preliminary review, Aetna must notify you of the results in writing. If your request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If your request is not complete, such notification will describe the information or materials needed to make the request complete. Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48-hour period following your receipt of the notification, whichever is later.

Referral to an External Review Organization (ERO)

If you are eligible for External Review, Aetna will assign an ERO accredited as required under federal law to conduct the External Review. The assigned ERO will notify you in writing of the request’s eligibility and acceptance for External Review. The assigned ERO will also provide an opportunity for you to submit in writing, within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review.

The ERO will review all of the information and documents timely received. In reaching a decision, the ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process. In addition to the documents and information provided, the ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;
(ii) The attending health care professional’s recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the Plan, Aetna, you or your treating provider;
(iv) The terms of the Plan to ensure that the ERO’s decision is not contrary to the terms of the Plan, unless the terms are inconsistent with law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal Government, national or professional medical societies, boards, and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law;
(vii) The opinion of the ERO’s clinical reviewer.

The assigned ERO must provide written notice of its decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of its decision to you, Aetna and the Plan.

Upon receipt of a notice that a Final Internal Adverse Benefit Determination has been reversed by an ERO, the Plan must immediately provide coverage or payment for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
(b) A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care
item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the requirements set forth above. Aetna must notify you of its eligibility determination immediately.

**Referral of Expedited Review to ERO**

Upon a determination that a request is eligible for an expedited External Review, Aetna will assign an ERO. The ERO will render a decision as expeditiously as your medical circumstances require, but in no event more than 72 hours after the ERO received the request for an expedited External Review. If the initial notice of the ERO’s decision is not in writing, then within 48 hours after the time of that notice, the ERO must provide written confirmation of its decision to you, Aetna and the Plan.

**Voluntary Appeal to the Plan**

If you choose to file a voluntary appeal with the Plan following an adverse determination on External Review or a Final Internal Adverse Benefit Determination from Aetna or CVS Caremark, you must do so in writing within 30 days of delivery of the Final Internal Adverse Benefit Determination or, if later, within 30 days of delivery of an adverse decision on External Review. Send the following information:

- The specific reason for the appeal;
- Copies of all past correspondence with Aetna, CVS Caremark or any ERO (including any Explanations of Benefits); and
- Any applicable information that you have not yet sent to Aetna, CVS Caremark, or an ERO.

Mail your appeal to:

CarMax, Inc. - Plan Administrator
12800 Tuckahoe Creek Parkway
Richmond, Virginia 23238-1115

The Plan will decide your appeal within 90 days of receipt and will notify you of its decision in writing. The filing of a voluntary appeal will have no effect on your rights to any other benefits under the Plan. If you choose not to file a voluntary appeal, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice. In addition, if you choose to file a voluntary appeal, any deadlines to bring a legal claim will be suspended until your voluntary appeal is complete. There is no cost to file a voluntary appeal. Please consult the Plan Administrator for more information on voluntary appeals, including information about the parties who are responsible for deciding appeals.
Deadline to Bring Legal Action

You must complete the first and second-level appeals described above before you may bring legal action. You may not file a lawsuit if your initial claims or appeals are not made within the time periods set forth above.

Once you have completed a first and second-level appeal, you must file any lawsuit related to your claim within 90 days of delivery of the final decision on the Final Internal Adverse Benefit Determination. You may not file suit after this 90-day period expires. However, if you file a timely request for External Review or a Voluntary Appeal to the Plan Administrator, this 90-day period and any applicable statute of limitations will be tolled while such request or voluntary appeal is pending.

Appealing an Enrollment or Eligibility Status Decision

If you disagree with the Plan’s determination regarding your enrollment or eligibility (other than COBRA enrollment or eligibility), or any other matter other than a claim for benefits, you have 90 days from the date of the determination to request an appeal. Send the appeal request to:

CarMax, Inc. - Plan Administrator  
12800 Tuckahoe Creek Parkway  
Richmond, VA 23238

The Plan Administrator will decide the appeal within 90 days after the date CarMax receives your appeal request, unless an extension is required.

If you disagree with the Plan’s determination regarding COBRA enrollment or eligibility, you have 90 days from the date of the determination to request an appeal. Send the appeal request to:

OneSource Virtual – COBRA Administrator  
9001 Cypress Waters Blvd.  
Dallas, TX  75019

Your appeal will be processed in accordance with the guidelines established by the Plan’s third-party COBRA administrator. To request information concerning these guidelines, contact the MYKMXXHR Service Center at (888) 695-6947.

You must complete the appeal described above before you may bring legal action related to the Plan’s determination regarding your enrollment or eligibility, or any other matter other than a claim for benefits. You may not file a lawsuit if your initial claim or appeal is not made within the time periods set forth above. Once you have completed an appeal, you must file any lawsuit related to your claim within 90 days of delivery of the final decision. You may not file suit after this 90-day period expires.

Forum for Legal Action

Any lawsuit related to your claim or this Plan may only be brought by you or your representative in Federal District Court in Richmond, Virginia, which will be the exclusive forum for such suits.
When Coverage Ends

Unless otherwise specified in this document, coverage under this Plan will end on the earliest of the following:

The Associate’s Coverage

- The last day of the month in which the Associate’s employment ends, including termination due to retirement
- The last day of the month during which you voluntarily terminate your coverage when permitted by the Plan (i.e., a Change in Status event)
- The last day of the month in which eligibility for coverage ceases
- The last day of the month for which required contributions were made
- When the Plan terminates

The Dependents’ Coverage

- The last day of the month in which eligibility ceases for Associate and Child, Associate plus Children, Associate and Spouse/Domestic Partner, or Family coverage
- The last day of the month in which coverage ends
- The last day of the month for which required contributions were made
- When the Plan terminates

Coverage for an individual dependent also stops on the last day of the month in which one of the following happens:

- The dependent becomes covered as an Associate under this Plan
- The dependent no longer meets the definition of an eligible dependent

If the Associate dies while covered as an active employee, any then-existing coverage for eligible dependents may continue for up to three months after the Associate’s death at no cost to the family, provided the covered dependents elect to continue coverage under COBRA. After the three months, dependents may continue their COBRA coverage for the balance of the COBRA period (the balance of the 36 months), provided that they continue to pay the applicable COBRA premium.

Benefits Available after Coverage Ends

If hospitalized when coverage ends, benefits will continue to be payable for inpatient Hospital care and treatment provided that (1) the expenses are not payable under any other group plan and (2) the entire hospitalization is for the same cause as the admission. These provisions apply only until the earliest of:

- The date the inpatient Hospital stay ends
- The date the person becomes covered for that condition under another group plan

Rescission in the Event of Fraud or Intentional Misrepresentation

This Plan prohibits fraud, deception, and intentional misrepresentations of material fact in the use of Plan services. As permitted by law, your coverage and the coverage of your dependents may be terminated or rescinded, including a retroactive cancellation and recovery of any payment of claims, if you engage in such acts or knowingly permit such acts by another.
Optional Continuation of Coverage (COBRA)

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), you and your qualified beneficiaries (that is, your enrolled Spouse and enrolled dependents) may continue group health coverage for a period of time listed in the chart below if coverage under the Plan ceases due to any of the following events:

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>COBRA Continues for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment terminates (except if you are discharged for gross misconduct) or your working hours are reduced resulting in a termination of coverage</td>
<td>Up to 18 months for you and/or your qualified beneficiaries</td>
</tr>
<tr>
<td>Total disability (as defined by the Social Security Administration) occurring during the 18-month period (^{(1)})</td>
<td>Up to 29 months for you and/or any of your qualified beneficiaries (see Note below)</td>
</tr>
<tr>
<td>Divorce or legal separation</td>
<td>Up to 36 months for your qualified beneficiaries</td>
</tr>
<tr>
<td>Your entitlement to Medicare</td>
<td>Up to 36 months for your qualified beneficiaries who are not entitled to Medicare</td>
</tr>
<tr>
<td>Death</td>
<td>Up to 36 months for your qualified beneficiaries</td>
</tr>
<tr>
<td>A dependent becomes ineligible for coverage as a “dependent child”</td>
<td>Up to 36 months for your enrolled child</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Note: If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan’s COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must notify the COBRA Administrator of your disability within 60 days of the latest date of: (a) the date the Social Security Administration determination that you are or your dependent is disabled, (b) the Qualifying Event date, (c) the loss of coverage date, or (d) the date you were or your dependent was notified of your obligation to provide the notice in order for your COBRA coverage to be extended up to the additional 11 months. The COBRA Administrator may be reached at (888) 695-6947.

**USERRA Continuation Coverage Rights** – If you are absent from employment due to service in the uniformed services, including active duty and training in the U.S. Armed Services, the Army National Guard, and Air National Guard, or the commissioned corps of the Public Health Service, you and/or your qualified beneficiaries are entitled to up to 24 months of continuation coverage.

**Second Qualifying Event** – If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the Associate or former Associate dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If benefits are being continued under a separate section of the Plan, then those benefits will run concurrently with the benefits provided under this section.
If you have elected coverage for your Domestic Partner, your Domestic Partner will also be eligible for similar, limited continuation coverage under the CarMax Domestic Partner Benefits Policy. However, the maximum continuation period of coverage for a Domestic Partner is 18 months after the “Qualifying Event” that resulted in the loss of coverage. The Domestic Partner may not elect coverage for dependents at any time during the continuation period. Your Domestic Partner’s children, if enrolled, are not eligible for continuation of coverage unless they are also your dependents under the federal tax code.

**COBRA Notices**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, a reduction in hours of employment, death of the Associate, or the Associate becoming entitled to Medicare benefits (under Part A, Part B, or both), CarMax, as the employer, will notify the Plan Administrator of the qualifying event.

COBRA notices will be given to any of your qualified beneficiaries at the time of your death. In the event of a divorce, legal separation or if a dependent child becomes ineligible under the group Plan, you or your qualified beneficiaries are required to notify the MYKMXHR Service Center within 60 days. Once you have notified the MYKMXHR Service Center, you and your qualified beneficiaries will be informed of your continuation rights.

In the event that you or your qualified beneficiaries experience a second qualifying event during the initial continuation coverage period, you or your qualified beneficiaries are required to notify the MYKMXHR Service Center within 60 days of such event. Once you have notified the MYKMXHR Service Center, you and your qualified beneficiaries will be informed of your additional continuation rights.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Associates may elect COBRA on behalf of their Spouses, and parents may elect COBRA on behalf of their children. COBRA notices will be given to any of your qualified beneficiaries at the time of your death. Once the election notice is received, an election must be made within 60 days. Your failure to make a written election during the 60-day period will be considered an election not to continue coverage. Under the law, the election not to continue coverage is irrevocable.

**Cost of COBRA Coverage**

To continue coverage, you or your dependents must pay the full cost of coverage plus the COBRA administration charge, which may be up to 2% of the cost of coverage. After the initial 18 months of COBRA coverage, if you qualify for the 11-month disability extension, the Plan is permitted to charge up to 150% of the cost of coverage. The Company is not responsible for paying any portion of the cost. If you elect COBRA continuation, you will be billed monthly.

**When COBRA Coverage Ends**

Continued coverage under the Plan will cease at the end of the appropriate 18-month, 24-month, 29-month, or 36-month period. However, coverage will cease earlier if any of the following occur:

- You or your qualified beneficiaries become entitled to Medicare or become enrolled in another comparable group health plan after your election to continue coverage under COBRA (to the extent that you or your dependents do not lose coverage in the new plan or are required to meet a pre-existing condition clause that affects any of you; if so, contact the MYKMXHR Service Center for details)
- Your former spouse remarries and becomes covered under his/her new spouse’s comparable group health care plan
- You or your qualified beneficiaries fail to make the required payment when it is due
- During the 11-month extension of coverage for disability, if the person no longer meets the Social Security definition of total disability

If you do not notify the Plan under the procedures and within the timeframes noted above, you may not be eligible for COBRA continuation coverage.
The Company discontinues group coverage for all employees covered under this Plan.

Keep the Plan Informed of Address Changes
In order to protect your family’s rights, you should keep the Plan Administrator and the Plan’s COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or the Plan’s COBRA Administrator.

If You Have Questions about COBRA Continuation Coverage
Questions concerning your COBRA continuation coverage rights should be addressed to the COBRA Administrator at (888) 695-6947.

Terminal Illness Provision (COBRA)
If an associate is diagnosed as permanently and totally disabled and “terminally ill” prior to the Qualifying Event which results in the initial loss or reduction of coverage, such individual will be eligible to continue coverage for him or herself and any covered dependents at the active Associate rates (meaning the Associate portion only, rather than the full COBRA rate) for up to 12 months after the Qualifying Event. The following definitions apply:

- A person is permanently and totally disabled if a disease or injury stops him or her from working at his or her own job or any other job for pay or profit.
- Suffers from an incurable, progressive, and medically recognized disease or condition; and
- Is not expected to survive more than 12 months beyond the date of the request for coverage under this provision.

Upon the (former) Associate’s death, the cost to continue coverage under COBRA for any surviving dependents will increase to the standard rates in effect for all COBRA continuants effective the first of the month following one calendar month after the former associate’s death. Eligible dependents will be able to continue coverage under COBRA for up to 36 months from the original Qualifying Event.

Members wishing to exercise this option must contact the MYKMXHR Service Center to apply. Call (888) 695-6947.
Important Notices

Comprehensive Notice of Privacy Practices - HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required by law to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required by law to follow the privacy practices described in this Notice and to provide you with a copy of this Notice, though it reserves the right to change those practices and the terms of this Notice at any time and to make those new terms effective for all PHI that it maintains. If it does so, and the change is material, you will receive a revised version of this Notice. This Notice, and any material revisions of it, will also be provided to you in writing upon your request, even if you have agreed to receive this Notice electronically (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by CarMax that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney)) may be required. Please review the following examples and descriptions of how the Plan may use and disclose your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). For example, doctors, hospitals and pharmacies that provide you care send the Plan information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received,
or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage or underwriting purposes. The Plan is not permitted to use or disclose genetic information for underwriting purposes.

**Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the Company so that the Company can perform plan administration functions.

- **Appointment Reminders and Treatment Alternatives** – The Plan also may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Required by law:** The Plan may disclose PHI where required by law, such as when a law requires that it report information about suspected abuse, neglect or domestic violence.

- **Law enforcement:** The Plan may disclose PHI for certain law enforcement purposes, such as related to suspected criminal activity.

- **Judicial Process:** The Plan may disclose PHI pursuant to a court order, subpoena, or other judicial process, as long as certain conditions are met.

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury or to report vital statistics to the public health authority.

- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to decedents:** The Plan may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Worker’s Compensation** – The Plan may disclose PHI consistent with applicable Worker’s Compensation laws.

- **Family Member** – The Plan may disclose PHI to a family member or close friend that you have identified and who is directly involved in your care or payment for your care.

- **Disaster Relief** – The Plan may disclose PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.
Uses and Disclosures Requiring Your Authorization.

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. This includes certain disclosures for marketing or sale of PHI, or where a disclosure involves psychotherapy notes. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object.

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI to these people only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Stricter State Privacy Laws. The Plan is required to comply with state laws, if any, that also are applicable and not contrary to the “HIPAA Privacy Rules.”

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

• To request restrictions on uses and disclosures: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but generally is not legally bound to agree to the restriction. To the extent that the Plan agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

• To choose how the Plan contacts you: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request if you state in writing that disclosing the information through normal means could endanger you.

• To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days, plus an allowed 30-day extension if needed. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, including electronic copies, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

• To request amendment of your PHI: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request, plus an allowed 30-day extension if needed. The Plan may deny the request if it is determined that the PHI is: (1) correct and complete; (2) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

• To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was
made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations or certain other exceptions. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing, plus an allowed 30-day extension if needed. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

- To be notified of security breaches. In certain cases, you have the right to be notified if there has been a breach of your unsecured protected health information.

**How to Complain about the Plan’s Privacy Practices.**

If you think the Plan or one of its vendors may have violated your privacy rights, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

**Contact Information.**

If you have questions about this Notice or on the Company’s privacy practices or wish to file a complaint, please contact: CarMax, Inc., Benefits Department, Attn: Privacy Manager, 12800 Tuckahoe Creek Parkway, Richmond, VA  23238.

**Effective Date.**

The effective date of this Notice is: April 14, 2003. This Notice was revised effective March 1, 2016.
Important Notice from CarMax about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CarMax and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CarMax has determined that the prescription drug coverage offered by the CarMax Health Care Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CarMax coverage will not be affected. You can keep your coverage if you elect Medicare Part D coverage and this plan will coordinate coverage.

If you do decide to join a Medicare drug plan and drop your current CarMax coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with CarMax and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the CarMax MYKMXHR Service Center at 888-695-6947. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CarMax changes. You also may request a copy of this notice at any time.
For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call (800) MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY (800) 325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).
Premium Assistance under Medicaid and the State Children’s Health Insurance Program (SCHIP) Notice

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage under the Plan, your state may have a premium assistance program that can help pay for coverage.

You can find additional information on the web at benefits.carmax.com under the “Notices” section of Plan information. A paper copy of the current SCHIP Notice is also available, free of charge, upon request by calling the MYKMXHR Service Center at (888) 695-6947.
Glossary

Many terms and phrases are defined throughout this booklet. Following is a list of additional terms and phrases that have not been defined elsewhere in this booklet. In all cases, terms and phrases that carry a specific definition have been capitalized.

**Alternative Health Care Services**
Alternative Health Care Services include, but are not limited to, Home Health Care, Hospice, and Skilled Nursing Facilities. Such services are subject to precertification requirements. Please refer to the “Precertification of Services” and “Precertification Penalties” sections.

**Ambulatory Surgical Center**
A specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- Is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
  - Is operated under the supervision of a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area;
  - Requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - Provides at least one operating room and at least one post-anesthesia recovery room;
  - Is equipped to perform diagnostic X-Ray and laboratory examinations or has an arrangement to obtain these services;
  - Has trained personnel and necessary equipment to handle emergency situations;
  - Has immediate access to a blood bank or blood supplies;
  - Provides the full-time services of one or more Registered Nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - Maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

**Allowed Amount**
The maximum amount on which payment is based for Covered Services. This may also be referred to as an “eligible expense,” “payment allowance” or “negotiated rate.”

**Associate**
Any person employed by the Employer, as such term is defined in the CarMax, Inc. Master Welfare Plan. The term Associate shall not include persons who are independent contractors, non-employee members of the CarMax, Inc. Board of Directors or who are considered to be self-employed individuals under IRS Code Section 401(C).

**Company**
CarMax, Inc., any successor that shall maintain this Plan, and any affiliates or participating employers listed in the Master Welfare Plan document.

**Covered Expenses**
The Recognized Charge to the Participant for Covered Services and supplies.

**Medically Necessary**
Health care services and supplies that a Physician or other health care provider, exercising prudent clinical judgment, would give to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or symptom of the above.
To be Medically Necessary, the provision of the service or supply must also be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease;
- Not mostly for the convenience of the patient, Physician, or other health care provider; and
- Not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

“Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with Physician specialty society recommendations. They must be consistent with the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Whether a service or supply meets this definition of Medically Necessary is determined by Aetna (or, in the case of benefits covered by the Plan’s pharmaceutical program, CVS Caremark).

**Nurse-Practitioner**
A person who is licensed or certified to practice as a Nurse-Practitioner and is licensed by a board of nursing as a Registered Nurse (RN) and has completed a program approved by the state for the preparation of Nurse Practitioners.

**Participant**
An Associate of the Employer or a non-employee member of the CarMax Board of Directors (and his/her covered dependents) who meets the eligibility requirements outlined under “Eligibility” and completes the enrollment requirements outlined under “Enrollment.”

**Physician**

**Primary Care Physician**
A physical (Medical Doctor or Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient. The Plan does not require you to designate a Primary Care Physician.

**Psychologist**
A person who specializes in clinical psychology and is licensed or certified as a Psychologist, or is a Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.
Recognized Charges
The amount of an Out-of-Network Provider’s charge that is eligible for coverage, which may be less than your provider’s full charge. You are responsible for all amounts above the Recognized Charge. The Recognized Charge is determined based on the Geographic Area where you receive the service or supply.

- The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If Aetna determines it needs more data for a particular service or supply, Aetna may base rates on a wider Geographic area, such as an entire state.

Except as otherwise specified below, and except in the case of emergency services, the Recognized Charge for each professional service or supply, including Hospitals and other facilities, is the lesser of what the Provider bills and the “reasonable amount rate.”

- The “reasonable amount rate” is established by Aetna as follows:
  - For professional services, the 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna reserves the right to substitute an alternative. If the alternative data source does not contain a value for a particular service or supply, Aetna will base the Recognized Charge on the Medicare allowable rate.
    - Except as specified below, the Medicare allowable rate is the rate the Center of Medicare Services (CMS) establishes for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, Aetna will determine the rate as follows:
      - Use the same method CMS uses to set Medicare rates.
      - Look at what other providers charge.
      - Look at how much work it takes to perform a service.
      - Look at other things as needed to decide what rate is reasonable for a particular service or supply.
  - For inpatient and outpatient charges of Hospitals or other facilities, the Facility Charge Review (FCR) rate.
    - The Facility Charge Review (FCR) Rate is an amount that Aetna determines is enough to cover the Provider’s estimated costs for the service and leave the Provider with a reasonable profit. For Hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on what the facilities report to CMS. For facilities which do not report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on statewide averages of the facilities that do report to CMS. Aetna may adjust the formula as needed to maintain the reasonableness of the Recognized Charge. For example, Aetna may make an adjustment if it determines that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

The Plan utilizes Aetna’s Aetna Choice POS II (Open Access) network. Aetna may also have a direct contract or, if there is no direct contract, a contract through any third party that is not an affiliate of Aetna, with providers who are not part of this network. In that case, the Recognized Charge is the rate negotiated by Aetna or its third-party provider.

The applicable Recognized Charge is determined by Aetna. Aetna has the right to apply Aetna reimbursement policies, which may further reduce the Recognized Charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- Whether follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided; and
- The educational level, licensure or length of training of the Provider.
Aetna’s reimbursement policies are based on its review of:

- The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of Physicians and dentists practicing in the relevant clinical areas.
General Information about This Plan

Plan Name

Type of Plan
Group Health Plan

Type of Administration
Administrative Services Only (i.e. self-funded).

Plan Sponsor
CarMax, Inc.
12800 Tuckahoe Creek Parkway
Richmond, VA 23238
(804) 747-0422

Plan Administrator
CarMax, Inc. - Benefits Administrative Committee
12800 Tuckahoe Creek Parkway
Richmond, VA 23238
(804) 747-0422

The plan is administered by the Benefits Administrative Committee, which is the Plan Administrator for ERISA purposes. The Committee has the authority to amend the Plan in all respects at any time for any reason; provided, however, that any amendment that is financially material to CarMax or its shareholders must be approved by the Board of Directors of CarMax, Inc. The Board of Directors has the authority to terminate the Plan at any time for any reason.

Agent for Service of Legal Process
CarMax, Inc.
12800 Tuckahoe Creek Parkway
Richmond, VA 23238
Attn: Corporate Secretary

Employer Identification Number (EIN)
54-1821055

Plan Number
503

Plan Year
The financial records of the Plan are kept on a March 1 through February 28/29 Plan Year. The Plan Year ends on each February 28/29.

Funding
The Health Care Plan is funded with contributions from both CarMax (out of its general assets) and the Associates participating in the Plan, as determined by CarMax in its sole discretion. These contributions are paid to Aetna and CVS Caremark to pay claims and Plan expenses. Aetna is responsible for administering claim payments and providing managed care services for medical benefits in accordance with the Plan's provisions. CVS Caremark is responsible for administering claim payments and providing prescription drug services in accordance with the Plan's provisions.
Other

In the event the relevant facts about your enrollment are inaccurate or administrative errors occur, an adjustment will be made. Additional contributions from you or a refund to you may be required to correct the situation. In any event, the terms of the Plan and/or Company policies will prevail.

The benefits described in this document do not constitute or imply employment contracts or any other contractual obligations between the Company and its Associates and/or other individuals eligible to participate in this Plan.

CarMax retains the right to modify or terminate this Plan or any of these benefits without the consent of or notice to Participants, Associates or other individuals eligible to participate in this Plan. The Company maintains this Plan by choice, not obligation.
Participant’s Rights under ERISA

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you are entitled to:

**Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

You may be entitled to continue coverage under this Plan for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the requested materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the Plan’s internal claims and appeals procedures described in this SPD, you may file suit in a federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).
Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need help obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hot-line of the Employee Benefits Security Administration or by visiting www.dol.gov/ebsa.