Middlesex County Joint Health Insurance Fund

Aetna HMO Plan

Welcome!

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Health Maintenance Organization (HMO) benefits program is self-funded by your employer and administered by Aetna Life Insurance Company (Aetna).*

We wish you the best of health.

** As used in this booklet, "HMO" refers to HMO-type benefits that are self-funded by your employer.*

How to Use Your Plan Description

This booklet is your guide to the benefits available through your employer's HMO Plan. Please read it carefully and refer to it when you need information about how the Plan works, to determine what to do in an emergency situation, and to find out how to handle service issues. It is also an excellent source for learning about many of the special programs available to you as a Plan participant.

If you cannot find the answer to your question(s) in the booklet, call the Member Services toll-free number on your ID card. A trained representative will be happy to help you. For more information, go to the "Member Services" section later in this book.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.
- Emergencies are covered anytime, anywhere, 24 hours a day. See "In Case of Medical Emergency" for emergency care guidelines.

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How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training.

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, **you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment**.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Schedule of Benefits."

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. **Except for those benefits described in this booklet as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides**.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Schedule of Benefits."

For inpatient expenses and surgery performed in an outpatient facility, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your **coinsurance**. Once your copayments and coinsurance amounts reach the **annual out-of-pocket maximum**, the Plan pays 100% of your covered expenses for the remainder of that calendar year.

To avoid costly and unnecessary bills, follow these steps:

- **Consult your PCP first** when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require **both** a referral from your PCP **and** prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services**.
- If it is not an emergency and you go to a doctor or facility **without your PCP's prior written or electronic referral, you must pay the bill yourself**.
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

Remember: You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **www.aetna.com/docfind.** Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Schedule of Benefits

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Maximum Benefit	Unlimited
Annual Out of Pocket Limit	
Individual	$ 1,500 per calendar year
Family	$ 3,000 per calendar year
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$ 2 copay per visit
After Hours/Home Visits/Emergency Visits	100% (of the contracted rate) per visit
Routine Physical Examinations	The plan pays 100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** log onto the Aetna website www.aetna.com or call the number on the back of your ID card.*
Covered Persons ages 22 but less than 65: Maximum Visits per 12 months	1 visit

Covered Persons age 65 and over: Maximum Visits per 12 months	1 visit
Health Wellness Promotion Program	The plan pays 100% per visit No deductible applies.
Annual: • Blood tests and lifestyle behavior counseling for covered persons age 20 and over • A pap smear for female covered persons age 20 and over • Stool examination for presence of blood for covered persons age 40 or over • A mammogram for female covered persons age 40 or over Every 5 years: • Glaucoma test for covered persons age 35 and over A left sided colon examination of 35 or 60 centimeters for covered persons age 45 and over	
Preventive Care Immunizations Performed in a facility or physician's office	The Plan pays 100% per visit No deductible applies.
Well Woman Preventive Visits **Office Visits**	The Plan pays 100% per visit No copay or deductible applies.
Maximum Visits per 365 days	1 visit
Routine Cancer Screenings Outpatient	The Plan pays 100% per visit No Calendar Year deductible applies.

Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	The Plan pays 100% per visit No copay or deductible applies.
Obesity Maximum Visits per 12 months (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Misuse of Alcohol and/or Drugs Maximum Visits per 12 months	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Use of Tobacco Products Maximum Visits per 12 months	8 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services Female Contraceptive Counseling Services -Office Visits.	100% per visit
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the Physician Services office visit section of the Schedule of Benefits.	
Family Planning Services - Female Voluntary Sterilization Inpatient Outpatient	 100% per visit 100% per visit
Family Planning Services - Female Contraceptives Female Contraceptive Generic Prescription Drugs (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year deductible applies.
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year deductible applies.

FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No calendar year deductible applies.
Routine Eye Examinations direct access (no referral) to participating providers for periodic routine exams	100% (of the contracted rate) per visit
Eyeglasses/Contact Lenses	Discounts available through Aetna Vision Discount Program
Hearing Aids	$ 2 copay per visit (pay as billed) $ 1,000 per Plan participant per 24 months to age 16.

Specialty and Outpatient Care	
Specialist Office Visits	100% (of the contracted rate) per visit
Prenatal Care - for the first OB visit Subsequent Prenatal Visits	100% (of the contracted rate) 100% (of the contracted rate)
Infertility Services	100% (of the contracted rate) per visit
Advanced Reproductive Technology	Copay based on where service is provided
Allergy Testing	Copay based on where service is provided
Allergy Treatment Routine injections at PCP's office, with or without physician encounter (Copay waived if billed without any other office service)	$ 2 copay per visit

Outpatient Facility Visits Performed at a Hospital Outpatient Facility	100% (of the contracted rate) per visit
Chemotherapy	100% (of the contracted rate) per visit
Radiation Therapy	100% (of the contracted rate) per visit
Infusion Therapy	100% (of the contracted rate) per visit
Performed at a facility other than a Hospital Outpatient Facility	100% (of the contracted rate) per visit
Chemotherapy	100% (of the contracted rate) per visit
Radiation Therapy	100% (of the contracted rate) per visit
Infusion Therapy	100% (of the contracted rate) per visit

X-rays and Lab Tests Performed at a Hospital Outpatient Facility	100% (of the contracted rate) per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	100% (of the contracted rate) per visit
Performed at a facility other than a Hospital Outpatient Facility	100% (of the contracted rate) per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET)	100% (of the contracted rate) per visit
Outpatient Therapy (speech, occupational, physical) Treatment over a 60 consecutive day period per incident of illness or injury beginning with the first day of treatment	100% (of the contracted rate) per visit
Autism Spectrum Disorder	Covered according to the type of benefit
Chiropractic Care	100% (of the contracted rate) per visit
Home Health Care	100% (of the contracted rate) per visit
Hospice Care	100% (of the contracted rate) per visit
Diabetic Supplies and Equipment	100% (of the cost) per item
Durable Medical Equipment (DME)	100% (of the cost) per item

Prosthetic Devices	No copay - some prostheses must be approved in advance by Aetna

Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	100% (of the contracted rate) per admission The copayment percentage applies to all covered benefits incurred during an individual's inpatient stay.
Outpatient Morbid Obesity Surgery	100% (of the contracted rate) per service
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	100% (of the contracted rate) per admission

Skilled Nursing Facilities	100% (of the contracted rate) per admission
Hospice Facility	100% (of the contracted rate) per admission

Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery Performed at a Hospital Outpatient Facility	100% (of the contracted rate) per visit
Performed at a facility other than a Hospital Outpatient Facility	100% (of the contracted rate) per visit

Mental Disorders	
During a Hospital Confinement	100% (of the contracted rate) per admission The copayment percentage applies to all covered charges incurred during an individual's inpatient stay.
During a Residential Treatment Facility Confinement	100% (of the contracted rate) per admission The copayment percentage applies to all covered charges incurred during an individual's inpatient stay.
Maximum of unlimited days per calendar year	

Outpatient Mental Disorders Visits	100% (of the contracted rate) per visit

Substance Abuse	
Detoxification and Rehabilitation During a Hospital confinement	100% (of the contracted rate) per admission The copayment percentage applies to all covered charges incurred during an individual's inpatient stay.
During a Residential Treatment Facility confinement	100% (of the contracted rate) per admission
Maximum of **unlimited** days per **calendar year**	The copayment percentage applies to all covered charges incurred during an individual's inpatient stay.
Outpatient Substance Abuse Visits Detoxification	100% (of the contracted rate) per visit
Rehabilitation (Including Partial Hospitalization and Intensive Outpatient Programs)	100% (of the contracted rate)] per visit
Maternity Mother	100% (of the contracted rate) per admission
Newborn	100% (of the contracted rate) per admission
Emergency Care	
Hospital Emergency Room or Outpatient Department	$ 15 copay per visit
Urgent Care Facility	$ 15 copay per visit
Ambulance	100% (of the contracted rate) per trip
Prescription Drugs	Outpatient prescription drug coverage is administered by Express Scripts. Refer to the separate booklet describing the coverage available.

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your PCP or on referral from your PCP:

•Office visits with your PCP during office hours and during non-office hours.
•Home visits by your PCP.
•Treatment for illness and injury.
•Health education counseling and information.
•Periodic eye examinations. You may visit a participating provider without a referral for one exam every 12 months.
•Routine hearing screenings performed by your PCP as part of a routine physical examination.

Routine Physical Exams

Covered expenses include office visits to your or your dependents' **physician**, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings by blood lead measurement for lead poisoning for children, including:
  - Confirmatory blood lead testing, as specified by the New Jersey Department of Health
  - Medical evaluation
  - Any necessary medical follow-up treatment for lead poisoned children
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years

- Radiological services, lab and other tests given in connection with the exam
- For covered newborns:
  - An initial **hospital** checkup
  - Hearing loss screenings by appropriate electrophysiologic screening measures
  - Periodic monitoring for delayed onset hearing loss.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
•Services which are covered to any extent under any other part of this Plan;
•Services which are for diagnosis or treatment of a suspected or identified illness or injury;
•Exams given during your stay for medical care;
•Services not given by a physician or under his or her direction;
•Psychiatric, psychological, personality or emotional testing or exams;

Health Wellness Promotion Programs

Covered expenses include charges made in a health promotion program through health wellness examinations and counseling for the following services. These services are recommended at certain time periods of your or your dependents' life which are shown on your schedule of benefits.

- Blood tests to determine:
  - Blood hemoglobin
  - Blood glucose
  - Blood pressure
  - Blood cholesterol
- Stool examination for the presence of blood
- Colon exams:
  - A left-sided colon examination of 35 to 60 centimeters
  - A routine diagnostic examination, including but not limited to, a digital rectal examination and a prostate-specific antigen test
- A glaucoma eye test
- A pap smear
- A mammogram
- Recommended immunizations
- Lifestyle behavior counseling including:
  - Smoking control
  - Nutrition and diet recommendations
  - Exercise plans
  - Lower back protection
  - Weight control
  - Immunizations practices
  - Breast self-examination
  - Testicular self-examination
  - Seatbelt usage in motor vehicles

Limitations:
Unless specified above, not covered are charges for:
•Services which are covered to any extent under any other part of this Plan;
•Services which are for diagnosis or treatment of a suspected or identified illness or injury;
•Exams given during your stay for medical care;
•Services not given by a physician or under his or her direction;
•Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations

Covered expenses include charges made by your physician or a facility for:

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

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

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

Well Woman Preventive Visits

Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
•Services which are covered to any extent under any other part of this Plan;
•Services which are for diagnosis or treatment of a suspected or identified illness or injury;
•Exams given during your stay for medical care;
•Services not given by a physician or under his or her direction;
•Psychiatric, psychological, personality or emotional testing or exams.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

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

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

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

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

•Services which are covered to any extent under any other part of this Plan.

Important Notes:
Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.
For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your physician, log onto the Aetna website www.aetna.com, or call the member services at the number on the back of your ID card.

Screening and Counseling Services

Covered expenses include charges made by your physician in an individual or group setting for the following:

Obesity
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
•preventive counseling visits and/or risk factor reduction intervention;
•medical nutrition therapy;
•nutrition counseling; and
•healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

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

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products
Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes:
•preventive counseling visits;
•treatment visits; and
•class visits;

to aid in the cessation of the use of tobacco products.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations:

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

•Services which are covered to any extent under any other part of this plan;
•Services which are for diagnosis or treatment of a suspected or identified illness or injury;
•Exams given during your stay for medical care;
•Services not given by a physician or under his or her direction;
•Psychiatric, psychological, personality or emotional testing or exams.

Family Planning Services - Female Contraceptives

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

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting. They are subject to the contraceptive counseling services visit maximum shown in your Schedule of Benefits.

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

Contraceptives
Covered expenses include charges made by a physician or pharmacy for:
•Female contraceptives that are brand name or generic prescription drugs;
•Female contraceptive devices including the related services and supplies needed to administer the device;
•FDA-approved female: generic emergency contraceptives.

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

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
•Services which are covered to any extent under any other part of this Plan;
•Services and supplies incurred for an abortion;
•Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care;
•Services which are for the treatment of an identified illness or injury;
•Services that are not given by a physician or under his or her direction;
•Psychiatric, psychological, personality or emotional testing or exams;
•Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
•Male contraceptive methods, sterilization procedures or devices;
•The reversal of voluntary sterilization procedures, including any related follow-up care.

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.
- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Radiation therapy.
- Cancer chemotherapy.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
- Home health services provided by a participating home health care agency, including:

  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.

  Home health care services do not include **custodial care** or applied behavior analysis.

- Outpatient hospice services for a Plan participant who is terminally ill, including:

  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.

  Note: The Plan does **not** cover the following hospice services:

  - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - respite care when the patient's family or usual caretaker cannot, or will not, attend to the patient's needs.

- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).

- Reconstructive breast surgery following a mastectomy, including:

  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant,
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed, and
  - physical therapy to treat the complications of the mastectomy, including lymphedema.

- Infertility services, including seeing a participating provider to diagnose the underlying medical cause of infertility, assisted reproductive technology (ART) and any surgery needed to treat the underlying medical cause of infertility.

  For help using your comprehensive infertility health care services you may enroll with our National infertility unit. To enroll you can reach our dedicated national infertility unit at 1-800-575-5999.

  You are eligible for coverage if:
  - You are covered under this plan as an employee or as a covered dependent who is the employee's legal spouse.
  - There exists a condition that:
  - Is demonstrated to cause the disease of infertility.
  - Has been recognized by your or your partner's **physician** or infertility specialist and documented in your or your partner's medical records.

- You or your partner has not had a voluntary sterilization (which includes tubal ligation, hysterectomy and vasectomy) with or without surgical reversal, regardless of post reversal results.
- You or your partner does not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You or your partner have exhausted the comprehensive Infertility services benefits or have clinical need to move on to ART procedures based on our clinical policy bulletin. Such services did not result in a documented fetal heartbeat. ART services include:
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfers)
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery
  - Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
  - Charges associated with obtaining the spouse's sperm for ART services, when the spouse is also covered under this plan.
  - The procedures are done while not confined in a **hospital** or any other facility as an inpatient.
- You or your partner have met the requirement for the number of months trying to conceive and your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

You are	**Number of months of unprotected timed sexual intercourse:**	**Number of donor artificial insemination cycles:**	**You need to have an unmedicated day 3 FSH test done within the past:**	**The results of your unmedicated day 3 FSH test:**
A female under 35 years of age with a male partner	**A**. 12 months or more **or**	**B**. At least 12 cycles of donor insemination	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.
A female under 35 years of age without a male partner	Does not apply	Not covered	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.

You are	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles:	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female 35 years of age or older with a male partner	**A**. 6 months or more **or**	**B**. At least 6 cycles of donor insemination	6 months	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs. **If you are age 40 and older**, must be less than 19 mIU/mL in all prior tests to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.
A female 35 years of age or older without a male partner	Does not apply	Not covered	6 months	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs. **If you are age 40 and older,** must be less than 19 mIU/mL in all prior tests to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or

				embryos but not your own eggs.

You are	Number of months of unprotected timed sexual intercourse:	Number of donor artificial insemination cycles:	You need to have an unmedicated day 3 FSH test done within the past	The results of your unmedicated day 3 FSH test:
A male of any age with a female partner under 35 years of age	12 months or more	Does not apply	Does not apply	Does not apply
A male of any age with a female partner 35 years of age or older	6 months or more	Does not apply	Does not apply	Does not apply

Only cancer patients are eligible for fertility preservation. Fertility preservation involves the creation of embryos or the retrieval of eggs and sperm that are frozen for future use. Along with the eligibility requirements above, you or your partner are eligible for fertility preservation benefits if:

- You, your partner or dependent child has a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in infertility. Planned cancer treatments include:
  - Bilateral orchiectomy (removal of both testicles).
  - Bilateral oophorectomy (removal of both ovaries).
  - Hysterectomy (removal of the uterus).
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility.
- The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

You are	You need to have an unmedicated day 3 FSH test done within the past:	The results of your unmedicated day 3 FSH test:
A female under 35 years of age	12 months	Must be less than 19 mIU/mL in your most recent lab test to use your own eggs.
A female 35 years of age or older	6 months	**If you are less than age 40**, must be less than 19 mIU/mL in your most recent lab test to use your own eggs. **If you are age 40 and older**, must be less than 19 mIU/mL in all prior tests to use your own eggs.

Covered services for fertility preservation will be paid on the same basis as ART services benefits for individuals who are infertile and not diagnosed with cancer.

A cycle is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, "one" cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our national **infertility** unit and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Covered services for ESET will be paid on the same basis as any other ART services benefit.

- Autism spectrum disorder. Autism spectrum disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. Covered services include the services and supplies provided by a **physician** or behavioral health provider for the diagnosis and treatment of autism spectrum disorder. Treatment will be covered only if a **physician** or behavioral health provider orders it as part of a treatment plan.

  Certain early intensive behavioral interventions are covered such as applied behavior analysis. Applied Behavior Analysis is an educational service that is the process of applying interventions:
  - That systematically change behavior, and
  - That are responsible for observable improvements in behavior.

  Important Note: Applied behavior analysis requires precertification by Aetna. The network provider is responsible for obtaining precertification.

- Chiropractic services. Subluxation services must be consistent with Aetna's guidelines for spinal manipulation to correct a muscular skeletal problem or subluxation that could be documented by diagnostic X-rays performed by a participating radiologist.
- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a **physician** for the treatment of an illness or injury.

  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

  The request for any type of DME must be made by your **physician** and coordinated through Aetna.

- Diabetic Supplies and Equipment. The following equipment, supplies and education services for the treatment of diabetic conditions are covered when ordered or prescribed by a **physician** (or participating nurse practitioner or clinical nurse specialist) and obtained through a **participating provider**: blood glucose monitors and blood glucose monitors for the legally blind, test strips for glucose monitors and visual reading and urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar.

Coverage also includes diabetes self-management education to ensure that participants with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. Such coverage for self-management education and education relating to diet shall be limited to visits **medically necessary** upon the diagnosis of diabetes, where a **physician** (or participating nurse practitioner or clinical nurse specialist) diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a participant**'**s self-management, or where re-education or refresher education is necessary. Such education must be provided by a participating dietitian registered by a nationally recognized professional association of dietitians or a health professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators.

- Nutritional supplements – Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids (inherited metabolic diseases)., prescribed by a **physician** for the treatment of an illness or injury.

  The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

  - they are needed due to a change in your physical condition, or
  - it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

  The request for any type of DME must be made by your **physician** and coordinated through Aetna.

  Covered services include formula and low protein modified food products ordered by a **physician** for the treatment of phenylketonuria or an inherited disease of amino and organic acids (inherited metabolic diseases).

  For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a **physician** for the dietary treatment of any inherited metabolic disease.Low protein modified food products do not include foods that are naturally low in protein.

  Certain infant (birth through 12 months) formulas are covered when there is a diagnosis as having multiple food protein intolerance and a **physician** has prescribed specialized, non-standard, formulas; and there has not been a responsive result to trials of standard non-cow milk-based formulas including soybean and goat milk.

- Obesity Treatment. Covered expenses include charges made by a **physician,** licensed or certified dietician, nutritionist or **hospital** for the non-surgical treatment of obesity for the following outpatient weight management services:

  - An initial medical history and physical exam;
  - Diagnostic tests given or ordered during the first exam; and
  - Prescription drugs.

- Morbid Obesity Surgical Benefits

  Surgical treatment of **Morbid Obesity** is a Covered Benefit, when provided by a **participating provider** and when authorized in advance by Aetna. Coverage includes one surgical procedure within a two-year period, beginning with the date of the first **Morbid Obesity** surgical procedure, unless a multi-stage procedure is planned and approved by Aetna.

Coverage for Morbid Obesity Surgical benefits are only provided for referred care.

Refer to the Schedule of Benefits for applicable cost sharing provisions.

Unless specified above, not covered under this benefit are charges incurred for: Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other serivces and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity,** or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this booklet.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See "Behavioral Health" for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/skilled nursing facility..
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. (The blood or blood product itself is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:

  - cardiac rehabilitation, and
  - pulmonary rehabilitation.

- X-rays (other than dental X-rays), laboratory testing and diagnostic services.

- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – **after consulting with you** – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information").

Note: Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number shown on your ID card. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Disorders Benefits

You are covered for treatment of a **mental disorder** through **participating behavioral health providers as follows**:

- **Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximums, if any, shown on the Schedule of Benefits.**
- Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, hospital or non-hospital residential treatment facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximums, if any, shown on the Schedule of Benefits.

Substance Abuse Benefits

You are covered for the following services as authorized and provided by **participating behavioral health providers**:

- Outpatient care benefits are covered for **detoxification.** Benefits include diagnosis, medical treatment and medical referral services (including **referral** services for appropriate ancillary services) by your **PCP** for the abuse of or addiction to alcohol or drugs.
- You are entitled to outpatient visits to a **participating behavioral health provider** upon **referral** by your **PCP** for diagnostic, medical or therapeutic substance abuse rehabilitation services. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
- **Inpatient care benefits are covered for detoxification.** Benefits include medical treatment and **referral** services for **substance abuse** or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; **physicians**, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.
- You are entitled to medical, nursing, counseling or therapeutic **substance abuse rehabilitation** services in an inpatient, **hospital** or non-hospital **residential treatment facility**, appropriately licensed by the Department of Health, upon **referral** by your **participating behavioral health provider** for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

Prescription Drugs

The Plan covers only prescription drugs administered while you are an inpatient in a covered health care facility. Please refer to the separate booklet describing the outpatient prescription drug coverage available through Express Scripts.

Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by The Plan.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:

  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.

- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:

  - care, filling, removal or replacement of teeth,
  - dental services related to the gums,
  - apicoectomy (dental root resection),
  - orthodontics,
  - root canal treatment,
  - soft tissue impactions,
  - alveolectomy,
  - augmentation and vestibuloplasty treatment of periodontal disease,
  - prosthetic restoration of dental implants, and
  - dental implants.

- Drugs and medicines which by law need a physicians prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.
- Expenses that are the legal responsibility of Medicare or a third party payor.

- Experimental and investigational services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.
  This exclusion will not apply to drugs:

  - that have been granted treatment investigational new drug (IND) or Group c/treatment IND status,
  - that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute, or
  - that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.
    Refer to the "Glossary" for a definition of "experimental or investigational."

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Hearing aids, eyeglasses, or contact lenses or the fitting thereof, except as specified under "Your Benefits."
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Infertility services, except as described under "Your Benefits." The Plan does not cover:

  - Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
  - Any charges associated with:
    - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
    - Assisted reproductive technology services. These include but are not limited to In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intra-fallopian transfer (GIFT) and Cryopreserved embryo transfers
    - Cryopreservation of eggs, embryos, or sperm
    - Storage of eggs, embryos, or sperm
    - Thawing of cryopreserved eggs, embryos or sperm.
    - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
    - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Home ovulation prediction kits or home pregnancy tests.
  - The purchase of donor embryos, donor oocytes, or donor sperm.
  - Reversal of voluntary sterilizations, including follow-up care.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.

- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Private duty or special nursing care.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:

  - obtaining or continuing employment,
  - obtaining or maintaining any license issued by a municipality, state or federal government,
  - securing insurance coverage,
  - travel, and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.

- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:

  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health, injectable drugs not considered medically necessary or used for cosmetic, performance, or enhancement purposes, or not specifically covered under this plan,
  - drugs related to treatments not covered by the Plan, and
  - drugs related to the treatment of infertility, contraception, and performance-enhancing steroids.
  - Specific non-standard allergy services and supplies, including (but not limited to):
  - skin titration (rinkel method),
  - cytotoxicity testing (Bryan's Test),
  - treatment of non-specific candida sensitivity, and
  - urine autoinjections.

- Speech therapy for treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.

- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):

  - primal therapy.
  - chelation therapy.
  - rolfing.
  - psychodrama.
  - megavitamin therapy.
  - purging.
  - bioenergetic therapy.
  - vision perception training.
  - carbon dioxide therapy.

- Thermograms and thermography.
- Transsexual surgery, sex change or transformation. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.• Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):

  - treatment performed by placing a prosthesis directly on the teeth,
  - surgical and non-surgical medical and dental services, and
  - diagnostic or therapeutic services related to TMJ.

- Wilderness treatment programs (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.

Financial Sanctions Exclusion

If any benefit provided by this plan violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

> *An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:*
>
> - *Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;*
> - *Serious impairment to bodily function; or*
> - *Serious dysfunction of any bodily organ or part.*

Some examples of emergencies are:

- Heart attack or suspected heart attack.
- Poisoning.
- Severe shortness of breath.
- Uncontrolled or severe bleeding.
- Suspected overdose of medication.
- Severe burns.
- High fever (especially in infants).
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP **and** approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting.
- Earaches.
- Sore throat.
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a **prior written or electronic referral** from your PCP, subject to the specialist copay shown in the "Schedule of Benefits."

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

Special Programs

Incentives

In order to encourage covered persons to access certain medical services when deemed appropriate by the covered person in consultation with his or her **physician** or other service provider, Aetna may, from time to time, offer to waive or reduce a member's copayment, coinsurance, and/or a deductible otherwise required under the plan or offer coupons or other financial incentives. Aetna has the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Wellness Incentive

Upon completion of a health assessment, you will be eligible to participate in wellness activities that align with your results. A list of wellness activities is available from Aetna or your Employer. To contact Aetna, call the Member Services phone number appearing on your ID card.
For completing one wellness activity, you will receive a Benefit Award Amount. Your plan may also have a maximum benefit per calendar year. The type and value of a Benefit Award Amount and the maximum benefit are chosen by your Employer. The Benefit Award Amount and the maximum benefit for completed wellness activities are shown in the Schedule of Benefits. You may use your Benefit Award Amount to reduce any applicable deductible and/or payment limit required under this plan.

Only you and your dependent spouse are eligible for wellness incentives.

Aetna Discount Program

Save on a variety of products and services with the Aetna Discount Program. The discounts can help you save money on what matters most to you - because it's your health, your wellness and your life.

You can access these discounts at no additional cost to you. You can use them whenever you want, as many times as you want. There are no claim forms or referrals. And, your family members may be able to save, too.

At Home Products

Save on arm and wrist blood pressure monitors and much more for you and your family from **Omron Healthcare Inc.**

Books

Save on books, DVDs and other items purchased from the American Cancer Society Bookstore, the Mayo Clinic Bookstore and for yoga-related titles, Pranamaya.

Fitness

You and your family members can save on gym memberships[1] and name-brand home fitness and nutrition products that support your healthy lifestyle with services provided by GlobalFit®. The GlobalFit network has thousands of gyms in the United States, including national chains and independent local facilities.

[1]Participation in GlobalFit is for new gym members only. If you belong to a gym now or belonged recently, call GlobalFit to see if a discount applies.

Hearing
You can take care of your hearing and save money on products and services from Hearing Care Solutions and Hear PO®[1]. Save on hearing exams and hearing aids, get free in-office services, and more.

[1] Hear PO will be known as Amplifon Hearing Health Care as of March 1, 2015

LifeMart®
Get discounts on millions of products and services from thousands of merchants nationwide on the LifeMart shopping website. You can find discounts in categories such as travel, tickets, electronics, home, auto, grocery coupons, wellness, family care and much more.

Natural Products and Services[1]
Save on specialty health care services and natural products through the ChooseHealthy®[1] program. Get a discount off the normal fee for acupuncture, massage therapy, chiropractic and nutrition services. Also save on the retail price of health and wellness products on the ChooseHealthy website.

You can also save on online provider consultations through the Vital Health Network (VHN). You have access to the VHN network of doctors who provide online consultations and alternative remedies for a variety of conditions.

[1]The ChooseHealthy program is made available through American Specialty Health Administrators, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

How to learn more about and get your discounts
From Aetna Navigator®, your secure member website, select "Discounts" to read about each vendor's offering and how you can take advantage of the discounts on these products and services. Then link over to the vendors' websites to purchase products and services from them.

Vision
You can take care of your vision and save with EyeMed. Get discounts on eye exams, eyeglass frames and lenses, non-disposable contact lenses and solutions, LASIK eye surgery, sunglasses and more. The EyeMed network is a nationwide network of eye care providers at the following retail chains:

- Lenscrafters®
- Pearle Vision®
- Target Optical®
- Sears Optical® locations
- JCPenney Optical

In addition, there are thousands of independent eye care providers to choose from.

Weight Management

You can meet your weight loss goals, get healthier and save money with:

- CalorieKing® Program[1] and products
- Jenny Craig®[2] weight loss programs
- Nutrisystem®[3] weight loss meal plans

[1] If you are already a CalorieKing member you will need to terminate your current CalorieKing Account and rejoin to receive the Aetna discounted membership price.

[2] Plus the cost of food. Plus the cost of shipping,(if applicable). Offer applies to initial enrollment fee only and is valid only at participating Centers and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per Member. No cash value. Restrictions apply.

[3] The Aetna discount offers do not apply to any program in which you are already enrolled. To receive the discounted rate, you must wait until your current program ends. If you are enrolled in Auto-Delivery, you must cancel it and then re-enroll to receive the discounted rate.

Aetna Health Connections℠-- Disease Management Program

Aetna's ongoing commitment to improve care for all members includes the Aetna Health Connections℠ Disease Management program which will deliver comprehensive support services for the significant number of people who present with one or more chronic or recurring conditions, or are at high risk of developing additional chronic conditions. While traditional disease management programs focus on delivering education to at-risk members about a specific chronic condition, the Aetna Health Connections℠ Disease Management program is based on a holistic, rather than condition-focused, view of each member. Aetna's Disease Management program addresses more than 30 chronic conditions, which often present as co-morbidities, in a holistic fashion.

Aetna's Disease Management program fully integrates powerful, innovative technology with the educational and outreach benefits of a disease management program and has a precise method for identifying appropriate candidates for disease management through the combination of predictive modeling and actionability assessments. Specifically, the patented ActiveHealth Management CareEngine will monitor all members with disease management benefits 100% of the time attempting to identify gaps, errors, omissions or commissions. Regardless of their health status, Aetna's programs and web-based tools are designed to help members become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna’s innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit **http://www.aetna.com/products/health_education.html**.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know™ -- Hypertension and Cholesterol Management

Aetna created *Numbers To Know*™ to promote blood pressure and cholesterol monitoring. The *Numbers To Know* mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your **physician** should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an **Institute of Excellence** (**IOE**) facility or non-**IOE** is used. In addition, some expenses listed below are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

Charges for activating the donor search process with national registries.

Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your: biological parent, sibling or child.

Inpatient and outpatient expenses directly related to a transplant**.**

Charges made by a **physician** or transplant team.

Charges made by a **hospital,** outpatient facility or **physician** 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 **IOE** facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.

2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.

3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.

4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

Heart

Lung

Heart/ Lung

Simultaneous Pancreas Kidney (SPK)

Pancreas

Kidney

Liver

Intestine

Bone Marrow/Stem Cell transplant

Multiple organs replaced during one transplant surgery

Tandem transplants (Stem Cell)

Sequential transplants

Re-transplant of same organ type within 180 days of the first transplant

Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)

Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)

Re-transplant after 180 days of the first transplant

Pancreas transplant following a kidney transplant

A transplant necessitated by an additional organ failure during the original transplant surgery/process.

More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g. a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.

Services and supplies furnished to a donor when recipient is not a covered person.

Home infusion therapy after the Transplant Occurrence.

Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.

Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.

Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women With Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

Breast cancer information

Second opinion options

Information about community resources

Benefit eligibility

Help with accessing participating providers for:

Wigs

Lymphedema pumps

Call 1-888-322-8742 to reach Aetna's Breast Health Education Center.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Infertility Case Management and Education

Aetna's Infertility Case Management program is a comprehensive education and information resource for women experiencing infertility.

Depending on the plan selected, the program may guide eligible members to a select network of infertility providers for services. If services are covered under the member's benefits plan, the Infertility Case Management unit will issue any necessary authorizations.

Aetna's Infertility Case Management unit is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility.

Beginning Right Maternity Program™

The Beginning Right™ maternity program provides you with maternity health care information, and guides you through pregnancy. This program provides:

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and program case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, ***Pregnancy Risk Assessment***, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Eligibility

Who Is Eligible to Join the Plan

You are eligible to enroll in the Plan if you are a full-time employee of your employer and you work or reside in the Plan's service area.When you join the Plan, your spouse and your dependent children are also eligible to join. . A dependent child must be under the age of 26. Coverage will continue until end of the month in which the child attains the limiting age.

You may enroll your natural child, foster child, stepchild, legally adopted child, a child under court order, or a grandchild in your court-ordered custody.

No person may be covered as both an employee and a dependent under the Plan, and no person may be covered as a dependent of more than one employee.

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 31 days of the placement.

If Your Child Does Not Reside With You

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Your child's coverage under the Plan will then be the same as yours.

A child covered by the Plan who does not reside in an Aetna service area can choose a PCP in your network and return to your network service area for care.

In the event of an emergency that occurs outside of your service area, out-of-area dependents should obtain necessary care as described under "In Case of Emergency," then contact their PCP to coordinate follow-up care.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a court order requiring a parent to provide health care benefits to one or more children. Coverage under the Plan can be extended to a child who is covered by a QMCSO, if:

- The QMCSO is issued on or after the date your coverage becomes effective; and
- Your child meets the definition of an eligible dependent under the Plan; and
- You request coverage for the child in writing.

Coverage will be effective on the date of the court order.

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative within 31 days of the date you become eligible if you wish to participate in the Plan. If you do not return the form within the 31-day period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. Open enrollment is held each fall, and the elections you make will be in effect January 1 through December 31 of the following calendar year.

Change in Status

You may change coverage any time during the year because of a change in your status. A change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 31 days of the event. Otherwise, you must wait until the next employer's open enrollment period.

Note: Newborn children are automatically covered for 31 days after birth. To continue the coverage beyond 31 days, you must apply by submitting a change form to your Human Resources representative within the 31-day period.

Special Enrollment Period

You and your eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when you or your eligible dependent loses other health coverage or when you acquire a new eligible dependent through marriage, birth, adoption, or placement for adoption.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:

You or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c, and d are met:

a. you or your eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under the Plan.
b. you or your eligible dependent previously declined coverage under the Plan;

c. you or your eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated because you or your dependent lose eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce, or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of Plan coverage due to you or your dependent moving outside of the Plan's service area; and also the termination of health coverage including Non-**HMO**, due to plan termination;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package;
- with respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; and

d. you or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

Loss of eligibility does not include a loss due to failure of you or your dependent to pay **premiums** on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this Plan Description.

You will need to enroll yourself or a dependent for coverage within:

- 31 days of the loss of coverage under the other group health plan or other health insurance coverage;
- 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

The **Effective Date of Coverage** will be the first day of the first calendar month following the date the completed request for enrollment is received.

You or your eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any described in this plan description.

Special Enrollment Period When a New Eligible Dependent is Acquired:

When you acquire a new eligible dependent through marriage, birth, adoption or placement for adoption, the new eligible dependent (as well as you and other eligible dependents, if not otherwise enrolled) may be enrolled during a special enrollment period.

The special enrollment period is a period of 31 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the **Effective Date of Coverage** will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement of adoption.

You or your eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this plan description.

When Coverage Ends

Termination of Employee Coverage

Your coverage will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

Termination of Dependent Coverage

Coverage for your dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

Termination for Cause

A Plan participant's coverage may be terminated for cause. "For cause" is defined as:

- **Untenable relationship**: After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with you or a Plan participant of your family. You will be given 31 days advance written notice of the termination of coverage.
- **Failure to make copayments**: You or a member of your family fails to make any required copayment or any other payment that you are obligated to pay. You will be given 31 days advance written notice of the termination of coverage.
- **Refusal to provide COB information**: You or a member of your family refuses to cooperate and provide any facts necessary for Aetna to administer the Plan's COB provision. You will be given 31 days advance written notice of the termination of coverage.
- **Furnishing incorrect or incomplete information**: You or a member of your family willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in, or obtaining benefits from, the Plan. Termination will be effective immediately.
- **Fraud against the Plan**: This may include, but is not limited to, allowing a person who is not a participant of the Plan to use your Aetna ID card. Termination will be effective immediately.
- **Misconduct**: You or a covered member of your family abuses the system, including (but not limited to) theft, damage to the property of a participating provider, or forgery of drug prescriptions. Termination will be effective immediately.

No benefits will be provided to you and your family members once coverage is terminated.

Any termination for cause is subject to review in accordance with the Plan's grievance process. You may request that Aetna conduct a grievance hearing within 15 working days after receiving notice that coverage has been or will be terminated. Coverage will be continued until a final decision on the grievance is rendered, provided you continue to make required contributions. Termination may be retroactive to the original date of termination if the final decision is in favor of Aetna.

Family and Medical Leave

If your employer grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue coverage for yourself and your eligible dependents during your approved leave. You must agree to make any required contributions.

The continued coverage will cease when:

- You fail to make any required contribution;
- Your approved leave is determined by your employer to be terminated; or
- The Plan is discontinued.

In addition, any coverage for a dependent will not be continued beyond the date it would otherwise terminate.

If you do not return to work at the end of the approved leave, your employer may recover from you the cost of maintaining your benefits coverage during the entire period of the leave, unless the failure to return to work was for reasons beyond your control.

If coverage under the Plan terminates because your approved FMLA leave is deemed terminated, you may, on the date of termination, be eligible to continue coverage under COBRA on the same terms as though your employment terminated on that date. If, however, your employment is terminated because of your gross misconduct, you will not be eligible for COBRA continued coverage.

COBRA Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called "qualifying events") when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

Continuation of coverage for other reasons

To request an extension of coverage**,** just call the toll-free Member Services number on your ID card.

How can you extend coverage if you are totally disabled when coverage ends?

Your coverage may be extended if you or your dependents are totally disabled when coverage ends.

You are “totally disabled” if you cannot work at your own occupation or any other occupation for pay or profit.

Your dependent is “totally disabled” if that person cannot engage in most normal activities of a healthy person of the same age and gender.

You may extend coverage only for services and supplies related to the disabling condition until the earliest of:

- When you or your dependents are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage
- Your **lifetime maximum** benefit is reached

The extension of benefits shall not extend the time periods during which you and your dependents may:

- Enroll for continuation of coverage under any New Jersey Continuation law or COBRA
- Expand the benefits for such coverage nor
- Waive the requirements concerning the payment of premium contribution for any continuation plan selected

Continuation coverage for dependents

If you die while covered under this plan, any coverage then in force for the dependents will be continued, provided the **contract holder** continues to make premium payments. Your spouse's coverage will cease when the spouse remarries. Any dependent's coverage, including a spouse's, will cease upon the earliest of:

- The end of the 12 month period right after your death
- A dependent no longer meets the eligibility requirements
- A dependent becomes eligible for like coverage under this plan or any other plan providing group health benefits
- When the **contract holder** no longer provides coverage for the class of eligible enrollees of which you were part right before your death
- Any required premiums cease

If coverage is being continued for a dependent, a child born after your death will also be covered.

How can you extend coverage when getting inpatient care when coverage ends?

Your coverage may be extended if you or your dependents are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends. If coverage is terminated or discontinued and you are hospitalized prior to the termination date, all charges with respect to hospitalization will be considered on the date of admission for all services and supplies provided through the date of discharge.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
- When you no longer need inpatient care
- 36 months of coverage

The extension of benefits shall not extend the time periods during which you and your dependents may:

- Enroll for continuation of coverage under any New Jersey Continuation law or COBRA
- Expand the benefits for such coverage nor
- Waive the requirements concerning the payment of **premium** contribution for any continuation plan selected

Continuation of coverage during temporary lay-off or approved leave of absence.

If your coverage would terminate due to a temporary lay-off or an approved leave of absence, coverage may be continued for up 60 days, or as otherwise agreed upon by the **contract holder** and **Aetna**, if the **contract holder**:

- Pays the **premium** for such continued coverage and
- Provides continued coverage from us or its other sponsored health benefit plans to all eligible enrollees in the same class as yours whose coverage would otherwise terminate because of a temporary lay-off or approved leave of absence.

How can you extend coverage for hearing services and supplies when coverage ends?

If your coverage ends while you are not totally disabled**,** your plan will cover hearing services and supplies within 30 days after your coverage ends if:

- The **prescription** for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 60 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year beginning after the two year period following the child attaining the plan age limit. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until:

- The earlier of one year after the leave of absence begins, or
- The date coverage would otherwise end, or
- The date your dependent child no longer is a dependent child according to Who can be on your plan (who can be your dependent).

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness** or **injury.**
- Cause the dependent child to lose status as a full-time student under the plan, and
- Be certified by the treating **physician** as medically necessary due to a serious **illness** or **injury.**

The **physician** treating your child will be asked to keep us informed of any changes.

Over-age dependent continuation

How can you continue coverage for over-age dependents?

A child who meets these conditions may elect to be covered under the contract holder's plan until his or her 31 birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends below.

Over-age dependent means your child by blood or law who:	• Has reached the limiting age as described in the *Eligibility* section of this booklet, but is less than 31 years of age • Is not married or is not a domestic partner or is not in a civil union • Has no dependents of his or her own • Is either a resident of New Jersey or is enrolled as a full-time student at an accredited school • Is not covered under any other: - Group or individual health benefits plan - Group health plan - Church plan or health benefits plan • Is not entitled to Medicare on the date continuation coverage begins
Conditions for election An **over-age dependent** is only entitled to make an election for continued coverage if all of the following conditions are met:	• The **over-age dependent** must provide evidence of prior creditable coverage or receipt of benefits under: - A group or individual health benefits plan - A group health plan - Church plan or health benefits plan or - Medicare • The prior coverage must have been effect at some time prior to making an election for this **over-age dependent** coverage. • A parent of an **over-age dependent** must be enrolled as having elected dependent coverage at the time the **over-age dependent** elects continued coverage
Election of continuation The eligible **over-age dependent** may make a written election for coverage. The effective date of the continued coverage will be the later of:	• The date the **over-age dependent** gives written notice to us • The date the **over-age dependent** pays the first **premium** • The date the dependent would otherwise lose coverage due to attainment of the limiting age

• For a dependent whose coverage has not yet terminated due to the attainment of the limiting age	• Written election must be made within the 30 days prior to attainment of the limiting age. • If made later, it would result in a lapse of coverage.
• For a dependent who was not covered on the date he or she reached the limiting age,	• The written election may be made at any time.
• For a person who did not qualify as an **over-age dependent** because he or she failed to meet all requirements of an **over-age dependent**, but who subsequently meets all of these requirements	• Written election may be made at any time after the person meets all of the requirements.
Evidence of insurability is not required for the continued coverage.	
Continued coverage The continued coverage shall be identical to the coverage provided to the **over-age dependent's** parent covered under the plan. If coverage is modified for dependents under the limiting age, the coverage for **over-age dependents** shall also be modified in the same manner.	
• **Payment of Premium**	• The first month's **premium** will be determined by the effective date of the **over-age dependent's** election • Subsequent monthly **premiums** must be paid in advance, at the times and in the manner specified by **Aetna.**
• **Payment of Premiums Grace Period**	• First **premium** payment, 31 days after billing due date. • Subsequent **premium** payment is made within 31 days of the date it is due.
When continuation ends	
An **over-age dependent's** continued group health benefits end on the first of the following:	• The date the **over-age dependent**: - Attains age 31 - Marries or becomes a domestic partner or enters into a civil union - Acquires a dependent - Is no longer either a resident of New Jersey or enrolled as a full-time student at an accredited school or - Becomes covered under any other: ○ group or individual health benefits plan ○ group health plan ○ church plan or health benefits plan or ○ becomes entitled to Medicare • The end of the period for which

	premium has been paid for the **over-age dependent**, subject to the grace period for such payment • The date the plan ceases to provide coverage to the **over-age dependent's** parent who is covered under the plan • The date the plan under which the **over-age dependent** elected to continue coverage is amended to eliminate coverage for dependents • The date the **over-age dependent's** parent who is covered under the plan waives dependent coverage. Except, if you have no other dependents, the **over-age dependent's** coverage will not end as a result of your waiving dependent coverage.
What do you need to know?	• Once the **contract holder** has validated the parent of an **over-age dependent's** coverage, the *Temporary HINT Supplemental Enrollment Information Form* must be completed by the enrollee • We will bill the covered **over-age dependent** directly and enrollees will remit the **premium** directly to us. • Although you must continue eligibility under the plan for continued coverage of the dependent, the dependent must also meet the applicable eligibility rules. All cost sharing requirements and limitations will apply and will not be combined with your plan. **Covered benefits** incurred by the dependent will not contribute towards the family **deductible** and out-of-pocket maximums. Family incurred expenses will not contribute towards the **over-age dependent's deductible**s or out-of-pocket maximums. • The *When coverage ends* section of the booklet does not apply to an **over-age dependent**. • **Over-age dependents** who have made an election for continuation and whose

	coverage is later terminated are not eligible for the continuation provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or New Jersey Continuation under the group plan. • A dependent of an **over-age dependent** will not be covered for any **covered benefits** in the booklet. This would also include any newborn children.

Discontinuance and replacement provisions

This section determines a carrier's responsibility when one carrier's policy or contract replaces another carrier's plan providing similar types of coverage.

How is the responsibility between the prior carrier and new carrier determined?

Responsibility	**Prior carrier**	**New carrier**
Claims incurred on the day prior to the new carrier's effective date	Prior carrier	
Extension of benefits	Prior carrier	
This does not change even if the group policyholder, contract holder or other entity gets replacement coverage from a new carrier, decides to self-fund or decides to stop providing coverage.		
If you are eligible for coverage with the new carrier on the effective date of the new carrier's plan		New carrier
If you were covered under the prior plan on the date that plan ended and you are in an eligible class of covered employees on the effective date of the new carrier's plan		New carrier
If you are totally disabled on the date the prior carrier's plan ended	Prior carrier	

- The minimum amount of benefits to be provided by the new carrier are the prior carrier's plan minus any benefits payable or services or supplies provided by the prior plan.
- Coverage shall be provided by the new carrier until at least the earliest of the following:
  - The date the individual becomes eligible under the new carrier's plan
  - For each type of coverage, the date the individual's coverage would terminate in accordance with the new carrier's termination provision (for example, at termination of employment or ceasing to be an eligible dependent, as the case may be)
  - In the case of an individual who was totally disabled, and in the case of a type of coverage for which New Jersey law requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by New Jersey law.

What happens to the time you have already satisfied for any benefit waiting periods?
The new carrier will give you credit for this time. Your employer will confirm the time already satisfied with the prior carrier.

What happens to any amount of your deductible satisfied with the prior plan?
Credit is given for expenses occurring and claimed under the prior carrier's plan during the 90 days before the effective date of the new carrier's plan. Keep in mind, the new carrier must have a similar deductible provision for these expenses to match.

In any situation where determination of the prior carrier's benefit is required by the new carrier, at the new carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit or the determination itself by the new carrier.

Portability of Coverage

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, your employer will give you a certificate confirming your participation in the Plan when your employment terminates. Certificates can be obtained from your Human Resources representative.

Claims

Coordination of Benefits

A person may be covered for health benefits or services by more than one plan. If this happens, Aetna will coordinate what we pay or provide with what another plan pays or provides. This is called coordination of benefits (COB).

In this section, we explain how we determine which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits. It is also intended to preserve you and your dependents rights to coverage under all plans under which you and your dependents are covered.

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- The charge for any health care service, supply or other expense for you are responsible when the health care service, supply or other expense is covered at least in part by any of the plans involved, except where a law requires another definition, or as stated below.

  When this plan is coordinating benefits with a plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, allowable expense is limited to items covered under the other plan.

  We will not consider the difference between the cost of a private **hospital** room and that of a semi-private **hospital** room as an allowable expense unless the stay in a private room is **medically necessary** and appropriate.

  When this plan is coordinating benefits with a plan that limits coordination of benefits to a specific coverage, we will only consider corresponding services, supplies or other expense which the other plan considers an allowable expense.

Claim determination period means:

- A calendar year, or any part of a calendar year, during which you and your dependents are covered by this plan and at least one other plan and incurs allowable expense(s) under these plans.

Plan means:

- Coverage with which coordination of benefits is allowed. Plan includes:
  - Group insurance and group subscriber contracts, including insurance continued according to a federal or state continuation law
  - Self-funded arrangements of group or group-type coverage, including insurance continued according to a federal or state continuation law
  - Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued according to a federal or state continuation law
  - Group hospital indemnity benefit amounts that exceed $150.00 per day
  - Medicare or other governmental benefits, except when, according to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan

- Plan does not include:
  - Individual or family insurance contracts or subscriber contracts
  - Individual or family coverage through a health maintenance organization (HMO) or under any other prepayment, group practice and individual practice plans
  - Group or group-type coverage where the cost of coverage is paid solely by the covered person coverage being continued according to a federal or state continuation law will be considered a plan
  - Group hospital indemnity benefit amounts of $150.00 per day or less
  - School accident-type coverage
  - A state plan under Medicaid

Primary plan means:

- A plan whose benefits for your health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan will be the primary plan if either of the below exist:
  - The plan has no order of benefit determination rules, or it has rules that differ from those contained in this coordination of benefits section, or
  - All plans which cover you use order of benefit determination rules consistent with those contained in the coordination of benefits section and under those rules, the plan determines its benefits first.

Reasonable and Customary means:

- An amount that is not more than the usual or customary charge for the service or supply as determined by us, based on a standard which is most often charged for a given service by a **provider** within the same geographic area.

Secondary plan means:

- A plan which is not a primary plan. If you are covered by more than one secondary plan, the order of benefit determination rules of this coordination of benefits section will be used to determine the order in which the benefits payable under the multiple secondary plans are paid. The benefits of each secondary plan may consider:
  - The benefits of the primary plan(s) and
  - The benefits of any other plan which, under this coordination of benefits section, has its benefits determined before those of that secondary plan.

Here's how COB works

- We consider each plan separately when coordinating payments. The primary plan pays or provides services or supplies first, as though the secondary plan doesn't exist. If a plan has no COB provision, or if the order of benefit determination rules differ from those in this section, it is the primary plan. A secondary plan takes into consideration the benefits provided by a primary plan when, according to the rules below, the plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. During each claim determination period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary plan will pay more than it would have paid if it had been the primary plan. The method the secondary plan uses to determine the amount to pay is outlined below in the *Determining who pays* section.

  The secondary plan will not reduce allowable expenses for **medically necessary** and appropriate services or supplies on the basis that **precertification**, preapproval, notification or second surgical opinion procedures were not followed.

Determining who pays under a health plan

The benefits of the plan that covers you as an employee, member, subscriber or retiree will be determined before those of the plan that covers you as a dependent. The coverage as an employee, member, subscriber or retiree is the primary plan.

The benefits of the plan that covers you as an employee who is neither laid off nor retired, or as a dependent of such person, will be determined before those for the plan that covers you as a laid off or retired employee, or as such a person's dependent. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

The benefits of the plan that covers you as an employee, member, subscriber or retiree, or dependent of such person, will be determined before those of the plan that covers the person under a federal or state continuation law. If the other plan does not contain this rule, and as a result, the plans do not agree on the order of benefit determination, this portion of this provision is ignored.

If a child is covered as a dependent under plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

- The benefits of the plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the parent whose birthday falls later in the calendar year.
- If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the other parent for a shorter period of time.
- Birthday refers only to month and day in a calendar year, not the year in which the parent was born.
- If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule is ignored.

If a child is covered as a dependent under plans through both parents, and the parents are separated or divorced, the following rules apply:

- The benefits of the plan of the parent with custody of the child will be determined first.
- The benefits of the plan of the spouse of the parent with custody will be determined second.
- The benefits of the plan of the parent without custody will be determined last.
- If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that plan has actual knowledge of the terms of the court decree, then the benefits of that plan will be determined first. The benefits of the plan of the other parent will be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision is ignored.

If a child is covered as a dependent under plans through an individual who is not a parent such as a stepparent or grandparent, the individual will be treated as a parent for purposes of the order of benefits determination.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the plan that covers the employee, member or subscriber for a longer period of time will be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

How are benefits paid?

In order to determine which procedure to follow it is necessary to consider:

- How the primary plan and the secondary plan pay benefits
- Whether the **provider** who provides or arranges the services and supplies is in the network of either the primary plan or the secondary plan.

Benefits may be based on the reasonable and customary charge (R & C), or some similar term. This means that the **provider** bills a charge and you may be responsible for the full amount of the billed charge. In this section, a plan that bases benefits on a reasonable and customary charge is called an R & C plan.

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a **provider**, called a **network provider**, bills a charge, you may be responsible only for an amount up to the negotiated fee. In this section, a plan that bases benefits on a negotiated fee schedule is called a fee schedule plan. If you use the services of a non-network **provider**, the plan will be treated as an R & C plan even though the plan under which you are covered allows for a fee schedule.

Payment to the **provider** may be based on a capitation. This means that the HMO or other plan pays the **provider** a fixed amount per covered person. You are responsible only for the applicable **deductible**, **coinsurance** or **copayment**. If you use the services of a non-network **provider**, the HMO or other plan will only pay benefits in the event of **emergency services** or urgent care. In this section, a plan that pays **providers** based upon capitation is called a capitation plan. In the rules below, **provider** refers to the **provider** who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

A plan determined to be a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. Where a benefit is payable by both the primary and secondary plans on the basis of usual, customary and reasonable fees (UCR), the secondary plan will pay the difference between billed charges for allowable expenses and the amount paid by the primary plan as long as the amount is no greater than the amount the secondary plan would have paid if primary. The amount by which the secondary plan's benefits have been reduced will be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by you. As each claim is submitted, the secondary plan will determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

The benefits of the secondary plan will be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit will be reduced in proportion, and the amount paid will then be charged against any applicable benefit limit of this plan.

Primary plan is R & C plan and secondary plan is R & C plan

The secondary plan will pay the lesser of:

- The difference between the amount of the billed charges and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

When the benefits of the secondary plan are reduced as a result of this calculation, each benefit will be reduced in proportion, and the amount paid will be charged against any applicable benefit limit of the plan.

Primary plan is fee schedule plan and Secondary plan is fee schedule plan

If the **provider** is a **network provider** in both the primary plan and the secondary plan, the allowable expense will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible**, **coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

The total amount the **provider** receives from the primary plan, the secondary plan and you will not exceed the fee schedule of the primary plan. In no event will you be responsible for any payment in excess of the **copayment**, **coinsurance** or **deductible** of the secondary plan.

Primary plan is R & C plan and secondary plan is fee schedule plan

If the **provider** is a **network provider** in the secondary plan, the secondary plan will pay the lesser of:

- The difference between the amount of the billed charges for the allowable expenses and the amount paid by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

You will only be responsible for the **copayment**, **deductible** or **coinsurance** under the secondary plan if you have no responsibility for **copayment**, **deductible** or **coinsurance** under the primary plan and the total payments by both the primary and secondary plans are less than the **provider's** billed charges. In no event will you be responsible for any payment in excess of the **copayment**, **coinsurance** or **deductible** of the secondary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan

If the **provider** is a **network provider** in the primary plan, the allowable expense considered by the secondary plan will be the fee schedule of the primary plan. The secondary plan will pay the lesser of:

- The amount of any **deductible**, **coinsurance** or **copayment** required by the primary plan; or
- The amount the secondary plan would have paid if it had been the primary plan.

Primary plan is fee schedule plan and secondary plan is R & C plan or fee schedule plan

If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, the secondary plan will pay benefits as if it were the primary plan.

Primary plan is capitation plan or fee schedule plan or R&C plan and secondary plan is capitation plan

If you receive services or supplies from a **provider** who is in the network of the secondary plan, the secondary plan will be responsible to pay the capitation to the **provider** and will not be responsible to pay the **deductible**, **coinsurance** or **copayment** imposed by the primary plan. You will not be responsible to pay any **deductible**, **coinsurance** or **copayments** of either the primary plan or the secondary plan.

Primary plan is an HMO and secondary plan is an HMO

If the primary plan is an HMO plan that does not allow for the use of non-network **providers** except in the event of urgent care or **emergency services** and the service or supply you receive from a non-network **provider** is not considered as urgent care or **emergency services**, but the **provider** is in the network of the secondary plan, the secondary plan will pay benefits as if it were the secondary plan, except that the primary plan will pay out-of-network services, if any, authorized by the primary plan.

How COB works with Medicare

This section explains how the benefits under this plan interact with benefits available under Medicare.

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

You are also eligible for Medicare even if you are not covered if you:

- Refused it
- Dropped it, or
- Did not make a proper request for it

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. In the case of someone who is eligible but not covered, the plan may pay as if you are covered by Medicare and coordinates benefits with the benefits Medicare would have paid had you enrolled in Medicare. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

If you are eligible due to age and have group health plan coverage based on your or your spouse's current employment and:	**Primary plan**	**Secondary plan**
The employer has 20 or more employees	Your plan	Medicare
You are retired	Medicare	Your plan
If you have Medicare because of:		
End stage renal disease (ESRD)	Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.	Medicare Your plan
A disability other than ESRD and your employer has more than 100 employees	Your plan	Medicare
Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.		

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

We are primary	We pay your claims as if there is no Medicare coverage.
Medicare is primary	We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense.

Charges that satisfy your Part B deductible will be applied in the order received. We will apply the largest charge first when two or more charges are received at the same time.

How this plan works with automobile plans for automobile related injuries

This section explains how the benefits under this plan interact with benefits available when expenses are incurred as a result of an automobile related i**njury**.

Key terms

Automobile related i**njury** means:

- Bodily **injury** sustained by a person as a result of an accident:
  - while occupying, entering, leaving or using an automobile; or
  - as a pedestrian

  caused by an automobile or by an object propelled by or from an automobile.

Allowable expense(s) means:

- A **medically necessary**, reasonable and customary item of expense covered at least in part as an eligible expense by:
  - The policy
  - PIP, or
  - OSAIC

Eligible expense means:

- That portion of medical expense incurred for treatment of an **injury** which is covered under this plan without application of cash **deductibles** and **copayments**, if any or **coinsurance**.

Out-of-State Automobile Insurance Coverage (OSAIC) means:

- Any coverage for medical expenses under an automobile insurance policy other than PIP.

OSAIC includes automobile insurance policies issued in another state or jurisdiction.

PIP means:

- Personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determining who pays when there is an automobile plan for auto related injuries

This plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for you under this plan. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insured's under another automobile policy. This plan may be primary for one covered person, but not for another if the person has separate automobile policies and has made different selections regarding primacy of health coverage.

This plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to this plan. In that case this plan will be primary.

If there is a dispute as to which plan is primary, this plan will pay benefits as if it were primary.

If this plan is primary to PIP or OSAIC, it will pay benefits for **eligible health services** in accordance with its terms.

The rules of the coordination of benefits section of this plan will apply if:

- You are insured under more than one insurance plan, and
- Such insurance plans are primary to automobile insurance coverage

If this plan is secondary to PIP or OSAIC, the actual benefits payable will be the lesser of:

- The allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying cash deductibles and copayments, or
- The benefits that would have been paid if this plan had been primary.

If this plan supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Aetna Navigator® secure member website at www.aetna.com.
- **By phone:** Call the toll-free number on your ID card.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid; or
- Any other plan that is responsible under these COB rules.

We will not seek reimbursement for an overpayment, except in the case of fraud or a pattern of inappropriate billing or claims later than 18 months after the date of the first payment on the claim.
We will not seek more than one reimbursement for overpayment of a particular claim.

We will not seek reimbursement for an overpayment from a **Provider** on or before the 45th calendar day following our request for reimbursement.

Recovery rights related to workers' compensation

If medical benefits are provided to you and your dependents by **Aetna** and workers' compensation for the same **illness** or **injuries**, we have the right to recover those benefits as described below.

Workers' compensation benefits include benefits paid in connection with a workers' compensation claim, whether:

- Paid by an employer directly
- A workers' compensation insurance carrier
- Any fund designed to compensate for workers' compensation claims

Aetna may exercise its recovery rights if the Deputy Directors or Referees of the Workers' Compensation Board incorporate into any:

- Award
- Order
- Approval of settlement

an order requiring the employer or the insurance carrier to reimburse us the amount of medical benefits paid by us.

The recovery rights will be applied even if we do not intervene in the action.

By accepting benefits under this plan, you and your dependents or your and your dependent's representatives agree to notify us of any workers' compensation claim made, and to cooperate with the process as described above.

Subrogation and Right of Recovery Provision

As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries, illness or condition, including the liability insurer of such party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage. For purposes of this provision, a "Covered Person" includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan member or person entitled to receive any benefits from the Plan.

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injuries, illness, to the full extent of benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Covered Person receives from all Responsible Parties. By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury or illness, he or she will serve as a constructive trustee over the fund that constitutes such payment. Failure to hold such fund in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Further, the Plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment, or otherwise, that a Covered Person receives from Responsible Party as a result of the Covered Person's illness, injuries, or condition.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

In the event that any claim is made that any part of this recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Claims, Appeals and External Review

Claims and Appeals

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to “you” in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims
An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the 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 it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the 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).

Other Claims (Pre-Service and Post-Service)
If the Plan requires you to obtain 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 not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after 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, they 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).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

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.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process
Generally, you are required to complete all appeal processes of the Plan before being able to bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Full and Fair Review of Claim Determinations and Appeals
Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. 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. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you 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 you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is **experimental or investigational** in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna’s decision. An external review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your **physician** certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Aetna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Appeal to the Company

If you choose to **appeal** to the Company following an **adverse determination** by External Review where applicable or an **adverse determination** at the final level of standard **appeals**, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with your Health Plan (including any EOBs); and
- Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize the Company to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Company Name: Middlesex County Joint Health Insurance Fund
Company Address: 8 Dickinson Dr., Blg. 300
Chadds Ford, PA 19031

The Company will review your appeal. The Company reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The Company reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The Company reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by the Company with respect to your claim shall be final and binding.

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). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the internet at **http://www.aetna.com/members/member_services.html** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number, Social Security number and e-mail address.

InteliHealth®

InteliHealth is Aetna's online health information affiliate. It was established in 1996 and is one of the most complete consumer health information networks ever assembled. Through this unique program, Plan participants have access, via the Internet, to the wisdom and experience of some of the world's top medical professionals in the field today. Access InteliHealth through the Aetna Internet website home page or directly via **www.intelihealth.com**.

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at **www.aetna.com**.

Aetna Navigator™

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from InteliHealth®. Access Aetna Navigator™ through the Aetna website home page or directly **via www.aetnanavigator.com**.

With Aetna Navigator, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **www.aetna.com**. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.

- Pay the copayments and coinsurance required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say **what** you want and **whom** you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, **or do not want**, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your PCP.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your PCP.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to **you**.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your "agent" or "proxy." Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your PCP to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your PCP, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. **If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records**.

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card.

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an **appropriate** mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed booklet. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call your Aetna contact number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:
- Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
- Screening and counseling services, such as:
- Interpersonal and domestic violence;
- Sexually transmitted diseases; and
- Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once -three years.
- A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits under your plan may be subject to visit maximums.

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

Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:
- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

- FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
- Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
- Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
- FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

The drug list is subject to change. Visit “Medication Search” on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Plan Information

Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2019. The plan description has been designed to provide a clear and understandable summary of the Plan.

Glossary

Advanced Reproductive Technology ("ART") - means:

a. in vitro fertilization (IVF);
b. gamete intra-fallopian transfer (GIFT);
c. zygote intra-fallopian transfer (ZIFT);
d. cryopreserved embryo transfers; or
e. intra-cytoplasmic sperm injection (ICSI) or ovum microsurgery.

Annual out-of-pocket maximum - means the maximum amount a Plan participant must pay toward covered expenses in a calendar year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. Copays (except prescription drug copays) and coinsurance amounts apply toward the annual out-of-pocket maximum.

Certain expenses do ***not*** apply toward the annual out-of-pocket maximum:

- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.

Behavioral Health Provider - means a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Body Mass Index - means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand Name Drug - means a prescription drug that is protected by trademark registration.

Coinsurance - means the sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 100% (the Plan's coinsurance), your coinsurance share is 0%.

Copayment (copay) - means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Schedule of Benefits."

Cosmetic surgery - means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) - means the types of medically necessary services and supplies described in "Your Benefits."

Creditable Coverage. - Coverage of the Plan participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace

Corps Act and the State Children's Health Insurance Program (S-Chip). Creditable Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

Custodial care - means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

Deductible - means the amount of covered, self-referred expenses that a Plan participant must pay each calendar year before the Plan begins paying benefits.

Detoxification - means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment (DME) - means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational - means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Generic Drug - means a prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home health services - means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care - means a program of care that is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital - means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

Infertility - means:

- For a female who is under age 35, the inability to conceive after one year or more without contraception or 12 cycles of artificial insemination.
- For a female who is age 35 or older, the inability to conceive after six months without contraception or six cycles of artificial insemination.

Infertility Case Management - means a program that consists of:

a. evaluation of infertile member's medical records to determine whether ART Services are Medically Necessary and are reasonably likely to result in success;

b. determination of whether ART Services are Covered Services and Supplies for the member;

c. pre-authorization for ART Services by a Participating ART Specialist when ART Services are Medically Necessary, reasonably likely to result in success, and are Covered Services and Supplies; and

d. case management for the provision of ART Services for eligible members.

Institute of Excellence (IOE)- This is a facility that is contracted with Aetna to furnish particular services and supplies to you and your covered dependents in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Medical services - means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary - means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered medically necessary:

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Mental Disorders - means 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.

The following conditions are considered a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Morbid Obesity. A Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid medical condition, including significant cardiovascular disease, sleep apnea, or uncontrolled type-2 diabetes.

Outpatient - means:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

Partial hospitalization - means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating ART Specialist - means a Specialist who has entered into a contractual agreement with Aetna for the provision of ART Services.

Participating provider - means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician - means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan benefits - means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this booklet.

Plan participant - means an employee or covered dependent.
Preferred Drug Guide - means a listing of prescription drugs and insulin established by the health plan, that includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. Drugs listed on the **preferred drug guide** are covered under the prescription drug plan, which copayments as shown in the "Schedule of Benefits".

Preferred Drug Guide Exclusions List - means a list of prescription drugs in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

Primary Care Physician (PCP) - means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider - means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Psychiatric Physician - means a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, **substance abuse** or **mental disorders**.

Referral - means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Residential Treatment Facility (Mental Disorders) - means an institution that meets all of the following requirements:

- On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
-
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- 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) - means an institution that meets all of the following requirements:

- On-site licensed **behavioral health provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **physician**.

- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending **physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
-
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- 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.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **behavioral health provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

Service area - means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility - means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist - means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse - means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Terminal illness - means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

Urgent medical condition - means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and your employer. The information herein is believed accurate as of the date of publication and is subject to change without notice.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed booklet. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call your Aetna contact number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:
   - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
     - Screening and counseling services, such as:
       - Interpersonal and domestic violence;
       - Sexually transmitted diseases; and
       - Human Immune Deficiency Virus (HIV) infections.
     - Screening for gestational diabetes.
     - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once -three years.
   - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
   - Preventive counseling visits and/or risk factor reduction intervention;
   - Medical nutrition therapy;
   - Nutritional counseling; and
   - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

   Benefits under your plan may be subject to visit maximums.

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

   Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:
   - Preventive counseling visits;
   - Treatment visits; and
   - Class visits.

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

   The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

   Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

   - FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient education and counseling for women with reproductive capacity.
   - Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
   - Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
   - FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

   Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

   The drug list is subject to change. Visit "Medication Search" on your secure member website at www.aetna.com for the most up-to-date information on drug coverage for your plan.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) may not be included in the enclosed booklet. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of PPACA.

The following is a summary of the requirements under PPACA.

1. For non-grandfathered plans:
   a. Subject to any applicable age, family history and frequency guidelines, the following preventive services, to the extent they are not already, are covered under the plan at the Preferred Care level benefits only. Preventive services will be paid at 100% per visit and without cost-sharing such as payment percentages; copays; deductibles; and dollar maximum benefits:
      - Items or services with an "A" or "B" rating from the United States Preventive Services Task Force;
      - Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and
      - Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA").
   b. If the plan requires or recommends that you designate a primary care provider, you may select any participating primary care provider who is available to accept you. In addition, you may select any participating pediatrician as your child's primary care provider, if the provider is available to accept your child.
   c. If your plan requires the referral or authorization from the primary care provider before receiving obstetrical or gynecological care from a participating provider who specializes in obstetrics or gynecological care, this requirement no longer applies. Care includes the ordering of related obstetrical and gynecological items and services that are covered under your plan.
   d. You do not need prior authorization for the treatment of an emergency medical condition, even if the services are provided by a non-participating provider. Care provided by a non-participating provider will be paid at no greater cost to you than if the services were performed by a participating provider. You may receive a bill for the difference between the amount billed by the provider and the amount paid by Aetna. If a non participating provider bills you directly for an amount beyond your cost share for the treatment of an emergency medical condition, you are not responsible for paying that amount. Please send the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over the amount. Make sure your member ID number is on the bill.
   e. You have the right to appeal any action taken by Aetna to deny, reduce or terminate the provision or payment of health care services. When we have done this based on the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service, you have the right to have the decision reviewed by an external review organization.

2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.
   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.
d. The eligibility rules for children have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or solely dependent upon you for support will not apply. **Please Note**: For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent's plan, then that child may not be eligible to enroll in this Plan. Contact your Employer for further information.
e. If your coverage under the **Plan** is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Affordable Care Act (ACA) may not be included in the enclosed certificate of coverage. This may be because the language is still pending regulatory review and approval. However, please note that for new plans on or after January 1, 2014, and for non-grandfathered plans that renew on a date on or after January 1, 2014, Aetna is administering medical and outpatient prescription drug coverage in compliance with the following applicable components of the ACA.

The following is a summary of the recent changes under the ACA.

For details on any benefit maximums and the cost sharing under your plan, log onto the Aetna website www.aetna.com, call the Member Services number on the back of your ID card, or refer to the Summary of Benefit and Coverage document you have received.

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:

   - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
   - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
     i. aspirin for men and women age 45 and over;
     ii. folic acid for women planning or capable of pregnancy;
     iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
     iv. vitamin D supplementation for men and women age 65 and older;
     v. fluoride supplementation for children from age 6 months through age 5;
     vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;
     vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device

2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed $6,350 per person and $12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
   a. not include out-of-pocket maximums; or
   b. have separate maximums from the medical plan up to these same amounts; or
   c. have maximums that are combined with the medical plan up to these same amounts.

3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.

4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.

5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.