BENEFIT PLAN

GA Gold OAMC 1000 80/60

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

GA Gold OAMC 1000 80/60
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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Booklet-Certificate Base: GA Gold OAMC 1000 80/60

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident**, **injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, "*Termination of Coverage (Extension of Benefits)*" and "*Continuation of Coverage*" for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered under this plan. If you are an owner of the company that applied for coverage under this plan and no other sources of coverage or reimbursement are available to you for the services or supplies, then you will also be covered for **occupational injuries** and **occupational illnesses**. Other sources of coverage or reimbursement may include workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

Treatment Outcomes of Covered Services

Aetna is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

Notice

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

When Your Coverage Begins

Who Can Be Covered

How and When to Enroll

When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an "eligible class", as defined below; and
- You will need to meet the "eligibility date criteria" described below.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time employee, as defined by your employer.

Probationary Period

Once you enter an eligible class, you will need to complete a probationary period, as defined by your employer, before your coverage under this plan begins.

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows.

On the effective Date of the Plan

If you are in an Eligible Class on the effective date of your plan, your Eligibility Date is the effective date of this Plan or, if later, the date you complete the period of continuous service required by your employer. Your employer determines the criteria that is used to define the Eligible Class for insurance coverage under this Plan. Such criteria are based solely upon conditions related to your employment. See your employer for details.

After the effective Date of the Plan

If you are in an Eligible Class on the date of hire, your Eligibility Date is the effective date of this Plan or, if later, the date you complete the period of continuous service required by your employer. Your employer determines the criteria that is used to define the Eligible Class for insurance coverage under this Plan. Such criteria are based solely upon conditions related to your employment. See your employer for details.

Obtaining Coverage for Dependents

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

Coverage for Domestic Partner
To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.

Coverage for Dependent Children
To be eligible for coverage, a dependent child must be:
Under 26 years of age.
An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court order.
- Your grandchildren in your court-ordered custody.
- Any other child with whom you have a parent-child relationship.

Coverage for Handicapped Dependent Children
Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

How And When To Enroll

Initial Enrollment In The Plan
You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions, if any, for any contributory coverage. Your employer will determine the amount of your plan contributions, if any, which you will need to agree to before you can enroll. Remember plan contributions, if any, are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

Newborns are automatically covered for 31 days after birth. You will need to complete a change form and return it to your employer within the 31-day enrollment period.

Late Enrollment
If you do not enroll during the Initial Enrollment Period, or a subsequent annual enrollment period, you and your eligible dependents may be considered **Late Enrollees** and coverage may be deferred until the next annual enrollment period. If, at the time of your initial enrollment, you elect coverage for yourself only and later request coverage for your eligible dependents, they may be considered **Late Enrollees**.

You must return your completed enrollment form before the end of the next annual enrollment period.

However, you and your eligible dependents may not be considered **Late Enrollees** under the circumstances described in the "Special Enrollment Periods" section below.

Annual Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a **Late Enrollee** if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under another plan; and
  - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other **c**overage; and
- You or your dependents are no longer eligible for other coverage because of one of the following:
  - The end of your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Employer contributions toward that coverage have ended;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - COBRA coverage ends;
  - Death;
  - Divorce or legal separation;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- 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.

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

- 60 days of when other coverage ends;
- within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of coverage must be provided to **Aetna**. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 60 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 60 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to **Aetna** within 60 days of the change. If you do not return the form within 60 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 60 days of the placement;
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage;

When You Receive a Qualified Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 60 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 60-day period.

If you do not request coverage for the child within the 60-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When Your Coverage Begins

Your Effective Date of Coverage

If you have met all the eligibility requirements, your coverage takes effect on the later of:

- The date you are eligible for coverage; and
- The date you return your completed enrollment information; and
- Your application is received and approved in writing by **Aetna**; and
- The date your required contribution is received by **Aetna**.

If you do not return your completed enrollment information within 31 days of your eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Important Notice:
You must pay the required contribution in full.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

Note: New dependents need to be reported to **Aetna** within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

How Your Medical Plan Works

Common Terms

Accessing Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

Important Notes

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet-Certificate in a safe place for future reference.

Common Terms

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Open Access Gatekeeper PPO Medical Plan

This Open Access Gatekeeper Preferred Provider Organization (PPO) medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Open Access Gatekeeper PPO plan, you can directly access any **physician**, **hospital** or **other health care** provider (**network** or **out-of-network**) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through **network providers** or **out-of-network providers**.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, Limitations* and *Schedule of Benefits* sections to determine if medical services are covered, excluded or limited.

This Open Access Gatekeeper PPO plan provides access to covered benefits through a network of health care providers and facilities. These **network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**. This Open Access Gatekeeper PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **cost-sharing** will generally be lower when you use **network providers** and facilities.

Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefit* sections and your *Schedule of Benefits* to determine if any services are limited to network coverage only.

Your out-of-pocket costs may vary between **network** and **out-of-network** benefits. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular provider. Either **Aetna** or any **network provider** may terminate the **provider** contract or limit the number of patients accepted in a practice. If the **physician** initially selected cannot accept additional patients, you will be notified and given an opportunity to make another selection.

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Reporting of Claims* section of this Booklet-Certificate and the *Appeals Procedure* provision included with this Booklet-Certificate.

To better understand the choices that you have with your Open Access Gatekeeper PPO plan, please carefully review the following information.

How Your Open Access Gatekeeper PPO Medical Plan Works

The Primary Care Physician:

To access network benefits, you are encouraged to select a **Primary Care Physician (PCP)** from **Aetna**'s network of providers at the time of enrollment. Each covered family member may select his or her own **PCP**. If your covered dependent is a minor, or otherwise incapable of selecting a **PCP**, you should select a **PCP** on their behalf.

You may search online for the most current list of **network providers** in your area by using DocFind, **Aetna**'s online provider directory at www.aetna.com. You can choose a **PCP** based on geographic location, group practice, medical specialty, language spoken, or **hospital** affiliation. DocFind is updated several times a week. You may also request a printed copy of the provider **directory** through your employer or by contacting Member Services through e-mail or by calling the toll free number on your ID card.

A **PCP** may be a general practitioner, family **physician**, internist, pediatrician and, if available within the network, an obstetrician or gynecologist. Your **PCP** provides routine preventive care and will treat you for **illness** or **injury**.

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

Changing Your PCP

You may change your **PCP** at any time on **Aetna**'s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna**'s receipt and approval of the request.

Specialists and Other Network Providers

You may directly access **specialists** and **other health care** professionals in the network for covered services and supplies under this Booklet-Certificate. Refer to the **Aetna provider directory** to locate network **specialists**, **providers** and **hospitals** in your area. Refer to the *Schedule of Benefits* section for benefit limitations and out-of-pocket costs applicable to your plan.

Important Note
ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify **Aetna** immediately and a new card will be issued.

Continuity of Care

Existing Enrollees

The following applies when your **hospital** or **physician**:

- Stops participation with **Aetna** as a **network provider** for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the heath professional's ability to practice;

Aetna will continue coverage for an ongoing course of treatment with your current **hospital** or **physician** during a transitional period. Coverage shall continue for up to 90 days from the date of notice to you from **Aetna** that the provider terminated participation with **Aetna** as a **network provider.**

If you have entered the second trimester of pregnancy, the transitional period will include the time required for postpartum care directly related to the delivery.

The coverage will be authorized by **Aetna** for the transitional period only if the **hospital** or **physician** agrees:

- To accept reimbursement at the **negotiated charge** and cost sharing applicable prior to the start of the transitional period as payment in full;
- To adhere to quality standards and to provide medical information related to such care; and
- To adhere to **Aetna's** policy and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this Booklet-Certificate.

With regards to the continuity of coverage provisions described above, the notice of the event provided to you by **Aetna** will include specific instructions on how to request continuity of coverage during the transitional period.

New Enrollees

If your current **hospital** or **physician** does *not* have a contract with **Aetna**, new enrollees may continue an ongoing course of treatment with their current **hospital** or **physician** for a transitional period of up to 60 days from the effective date of enrollment. If you have entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the period of time that postpartum care directly related to the delivery is provided. You need to complete a *Transition of Coverage Request* form and send it to **Aetna**. Contact Member Services at the number on the back of your ID card for a copy of this form. If authorized by **Aetna**, coverage will be provided for the transitional period but only if the **hospital** or **physician** agrees to:

- Accept reimbursement at the **negotiated charge** and cost-sharing established by **Aetna** prior to the start of the transitional period as payment in full;
- Adhere to quality standards and to provide medical information related to such care; and
- Adhere to **Aetna's** policy and procedures.

This provision shall not be construed to require **Aetna** to provide coverage for benefits not otherwise covered under this Booklet-Certificate.

Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online **directory**, DocFind, for names and locations of **physicians** and other health care providers and facilities. You can change your **PCP** at anytime.
- If a service or supply you need is covered under the plan but not available from a **network provider** or **hospital** in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as **hospitalization, outpatient surgery** and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these services. You do not need to **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining the necessary **precertification** for you. Since **precertification** is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information.
- You will not have to submit medical claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** or facility less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** and **copayments**, if any.

You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayment**, or **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits.*

- **Network providers** have agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense**, incurred from a **network provider**, up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **coinsurance**. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **coinsurance** are usually lower when you use **network providers** than when you use **out-of-network providers**.
- For certain types of services and supplies, you will be responsible for any **copayments** shown in the *Schedule of Benefits*. The **copayments** will vary depending upon the type of service.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* for information on what expenses do not apply and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses** up to the maximum limits shown in the *Schedule of Benefits* and Booklet-Certificate. You are responsible for any expenses incurred over those maximum limits.
- You may be billed for any **deductible**, **copayment**, or **coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

You have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered benefits. You will still be covered when you use **out-of-network providers** for **covered expenses**. Your cost-sharing is usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Aetna** will only pay up to the **recognized charge**.

- **Precertification** is necessary for certain services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from **Aetna**. Your provider may **precertify** your treatment for you, however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified**, the benefit payable may be significantly reduced. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Medical Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, you may have to pay for services at the time that they are rendered. You may be required to pay the full charges. When you pay an **out-of-network provider** directly, you must submit a completed claim form and proof of payment to **Aetna** to receive reimbursement of **covered expenses** from **Aetna**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required of you by your plan. Refer to the *General Provisions* section of this Booklet-Certificate for details of how to file a claim under this plan.
- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note
Failure to **precertify** services and supplies provided by an **out-of-network provider** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Medical Precertification* section of this Booklet-Certificate for information on how to request **precertification**.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.

- **Out-of-network providers** have not agreed to accept the **negotiated charge. Aetna** will reimburse you for a **covered expense,** incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **coinsurance.** The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **coinsurance** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **coinsurance** are usually higher when you use **out-of network providers** than when you use **network providers.**
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.
- Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* for information on what expenses do not apply and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses** up to the maximum limits shown in the *Schedule of Benefits* and Booklet-Certificate. You are responsible for any expenses incurred over those maximum limits.

Important Note

ID Card: You will receive an ID card. It identifies you as a member when you receive services from health care **providers**. If you have not received your ID card or if your card is lost or stolen, notify us immediately and a new card will be issued to you.

Understanding Medical Precertification

Precertification

Certain services and supplies, such as inpatient **stays**, certain tests, procedures and **outpatient surgery** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

You do not need to **precertify** services and supplies provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the **network provider's** responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider's** failure to **precertify** services and supplies.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services and supplies on the **precertification** list. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services and supplies requiring **precertification** appears later in this section.

Important Note
Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

The Precertification Process

Prior to being **hospitalized** or receiving certain other medical services or supplies there are certain **precertification** procedures that must be followed.

You do not need to **precertify** services and supplies provided by a **network provider**.

You are responsible for obtaining **precertification** for services and supplies provided by an **out-of-network provider**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

Precertification should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your **physician** or the facility will need to call and request **precertification** at least 14 days before the date you are scheduled to be admitted.
For an **emergency medical condition**:	You or your **physician** should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an **emergency admission**:	You, your **physician** or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.

For an **urgent admission**:	You, your **physician** or the facility will need to call before you are scheduled to be admitted. An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an **illness**; the diagnosis of an **illness**; or an **injury**.
For outpatient non-emergency medical services requiring **precertification**:	You or your **physician** must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your **physician** of the **precertification** decision**,** where required under applicable State law. If your **precertified** services are approved**,** the approval is valid for 60 days as long as you remain enrolled in the plan**.** Premium that is due and unpaid at the time the **precertified** treatment/services are performed must be paid in full within the required timeframe.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** or services and supplies are not **covered expenses**, the notification will explain why and how **Aetna's** decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Procedure section included with this Booklet-Certificate.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital;**
- **Stays** in a **skilled nursing facility;**
- **Stays** in a **rehabilitation facility;**
- **Stays** in a **hospice** facility;
- **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**;
- Complex imaging;
- Cosmetic and reconstructive surgery;
- Emergency transportation by airplane;
- Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications);
- Kidney dialysis;
- Bariatric surgery (obesity);
- Outpatient back surgery not performed in a **physician's** office;
- Sleep studies;
- Knee surgery; and
- Wrist surgery.

How Failure to Precertify Affects Your Benefits

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses from an **out-of-network provider**. This means **Aetna** will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary **precertification** from **Aetna** prior to receiving services from an **out-of-network provider**. Your provider may **precertify** your treatment for you; however you should verify with **Aetna** prior to the procedure, that the provider has obtained **precertification** from **Aetna**. If your treatment is not **precertified** by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained prior to incurring medical expenses from an **out-of-network provider**.

If **precertification** is:	then the expenses are:
▪ requested and approved by **Aetna**	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a **precertification** benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your out-of-network **deductibles** or **Maximum Out-of-Pocket Limits**.

*Refer to the *Schedule of Benefits* section for the amount of **precertification** benefit reduction that applies to your plan.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's service area, for:

- An **emergency medical condition**; or
- An **urgent condition**.

In Case of a Medical Emergency

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** or **PCP** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** or **PCP** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** or **PCP** as soon as reasonably possible.

If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

Important Reminder
If you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

In Case of an Urgent Condition

Call your **physician** or **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **physician** or **PCP**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care facility** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna**'s online provider directory at www.aetna.com.

Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

Non-Urgent Care

If you seek care from an **urgent care facility** for a non-**urgent condition**, (one that does not meet the criteria above), the plan will not cover the expenses you incur unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

Important Reminder
If you visit an **urgent care facility** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care facility unless otherwise specified.

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

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** or **PCP** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room or **urgent care facility** for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your **physician** or **PCP**.

You may use an **out-of-network provider** for your follow-up care. You will be subject to the **deductible and coinsurance** that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice
Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should ***not*** be provided by an emergency room facility.

Requirements for Coverage

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:
   - Be included as a covered expense in this Booklet-Certificate;
   - Not be an excluded expense under this Booklet-Certificate. Refer to the *Pediatric Dental Exclusions, Medical Benefit Plan Exclusions* and *Pharmacy Benefit Limitations and Exclusions* sections of this Booklet-Certificate for lists of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* and *What the Pharmacy Benefit Covers* sections and the *Schedule of Benefits* for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.

2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.

   The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness**, **injury**, disease or its symptoms. The provision of the service or supply must be:

   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness**, **injury** or disease; and
   (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness**, **injury**, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

Important Note
Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain health services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* and *What the Pharmacy Benefit Covers* sections and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Open Access Gatekeeper PPO Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

Preventive Care Benefits

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

Important Reminder:

1. The recommendations and guidelines of the:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
   - United States Preventive Services Task Force;
   - Health Resources and Services Administration; and
   - American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents

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

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

3. Gender-Specific *Preventive Care* Benefits – **covered expenses** include any recommended *Preventive Care* Benefits described below that are determined by your provider to be **medically necessary**, regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

4. Refer to the *Schedule of Benefits* for information about cost-sharing and maximums that apply to *Preventive Care* benefits.

5. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna Navigator® secure member website at www. aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website.

Routine Physical Exams

Covered expenses include charges made by your **physician**, **primary care physician** (**PCP**) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a

medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** checkup.
- Bone density screening for osteoporosis.

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; and
- Psychiatric, psychological, personality or emotional testing or exams.

Preventive Care Immunizations

Covered expenses include charges made by your **physician**, **primary care physician (PCP)** 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:
- Services which are covered to any extent under any other part of this Plan; and
- Immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Child Wellness Services Expenses

The charges below are included as **covered expenses** even though they are not incurred in connection with an injury or disease. They are included only for a dependent child under 6 years of age.

Child Wellness Services Expenses are the charges for Child Wellness Services.

"Child Wellness Services" means **physician**-delivered or **physician** supervised services which shall include coverage for services delivered at the intervals and scope stated below. Included are:

- A review and written record of the child's complete medical history.
- Physical examination.
- Developmental and behavioral assessment.
- Anticipatory guidance.

- Appropriate immunizations.
- Laboratory tests.

All of the above will be in keeping with prevailing medical standards.

Covered expenses will only include charges of one **physician** for Child Wellness Services performed at birth and at approximately each of the following ages:

2 months	12 months	2 years
4 months	15 months	3 years
6 months	18 months	4 years
9 months		5 years

Not covered are charges incurred for:

- services which are covered to any extent under any other part of this Plan;
- services which are covered to any extent under any other group plan sponsored by your Employer;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- services not performed by a **physician** or under his or her direct supervision;
- medicines, drugs, appliances, equipment or supplies;
- dental exams**.**

Important Note:

Refer to the *Schedule of Benefits* for details about **deductibles**, **coinsurance**, benefit maximums and frequency and age limits for physical exams, if applicable. Any applicable deductible will not apply to child wellness services expenses.

Preventive Care Drugs and Supplements

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **pharmacy**. They are covered when they are:
- prescribed by a **physician**;
- obtained at a **pharmacy;** and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:
- *Aspirin:* Benefits are available to adults.
- *Oral Fluoride Supplements:* Benefits are available to children whose primary water source is deficient in fluoride.
- *Folic Acid Supplements:* Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- *Iron Supplements:* Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- *Vitamin D Supplements:* Benefits are available to adults to promote calcium absorption and bone growth in their bodies.

Risk Reducing Breast Cancer Prescription Drugs

Covered expenses include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:
- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

Important Note:
For details on the guidelines and the current list of covered preventive care drugs and supplements, including risk reducing breast cancer **prescription drugs**, contact Member Services by logging on to your Aetna Navigator® secure member website at www. Aetna.com or at the toll-free number on your ID card.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

Reimbursement of Preventive Care Drugs and Supplements at a Pharmacy

You will be reimbursed by **Aetna** for the cost of the preventive care drugs and supplements when you submit proof of loss to **Aetna** that you purchased a preventive care drug or supplement at **a pharmacy**. "Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (it is attached to the bag that contains the preventive care OTC drug or supplement).

Refer to the provisions *Reporting of Claims* and *Payment of Benefits* later in this booklet-certificate for information. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Well Woman Preventive Visits

- **Covered expenses** include charges made by your **physician**, **primary care physician** (**PCP**), obstetrician, or gynecologist for a routine well woman preventive exam office visit, including Pap smears and routine Chlamydia screening test. A routine well woman preventive exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**; and
- Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. **Covered expenses** include charges made by a **physician** and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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 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; and
- Psychiatric, psychological, personality or emotional testing or exams.

Screening and Counseling Services

Covered expenses include charges made by your **physician** or **primary care physician** (**PCP**) in an individual or group setting for the following:

Obesity and/or Healthy Diet
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
- Preventive counseling visits and/or risk factor reduction intervention;
- 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.

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.

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

Coverage includes:
- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.

Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and
- Candy-like products that contain tobacco.

Sexually Transmitted Infection Counseling
Covered expenses include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic Risk Counseling for Breast and Ovarian Cancer
Covered expenses include the counseling and evaluation services to help you assess whether or not you are at risk of breast and ovarian cancer.

Benefits for the screening and counseling services above are subject to any visit maximums shown in your *Schedule of Benefits***.**

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.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:
- Mammograms;
- Cytologic screening;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE);
- Colonoscopies; (removal of polyps performed during a screening procedure is a **covered expense**);
- Lung cancer screenings; and
- Bone density measurement screening for the diagnostic and evaluation of osteoporosis or low bone mass. Screening includes, but is not limited to, x-rays and ultrasounds.

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.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers one baseline mammogram for a woman age 35 and over or when medically necessary and bone density measurement screening.

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 Reminder:
1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Preventive Care*.
2. 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 Member Services at the number on the back of your ID card.

Prenatal Care

Prenatal care will be covered as *Preventive Care* for services received by a pregnant female in a **physician's**, **primary care physician's** (**PCP**), obstetrician's, or gynecologist's office but only to the extent described below.

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

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for:
- Services which are covered to any extent under any other part of this Plan; and
- Pregnancy expenses *(other than prenatal care as described above)*.

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

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits***.**

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

Breast Pump
Covered expenses include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.

- The purchase of:
    - An electric breast pump (non-hospital grade),. A purchase will be covered once every three years; or
    - A manual breast pump. A purchase will be covered once per pregnancy.
    - If an electric breast pump was purchased within the previous three year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.

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

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

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

Limitations:
Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

Family Planning Services - *Female Contraceptives*

Important Note:
For a list of the types of female contraceptives covered under this Plan, refer to the section *What the Pharmacy Plan Covers* and the *Contraceptives* benefit later in this *Booklet-Certificate*.

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**, **primary care physician's** (**PCP**), 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:

Voluntary Sterilization
Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

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

Contraceptives
Covered expenses include charges made by a **physician** or **pharmacy** for:
- Services and supplies needed to administer or remove a covered contraceptive **prescription drug** or device;
- Female oral and injectable contraceptive that are **generic prescription drugs**;
- Female contraceptive devices that are generic devices and brand name devices;
- FDA-approved female:
    - generic emergency contraceptives approved by the FDA. To the extent one of the emergency contraceptive methods are not available as a generic, a brand name emergency contraceptive will be covered.

- generic over-the-counter (OTC) emergency contraceptives for which a **prescription** is not needed. Coverage is limited to 1-5 emergency contraceptive(s) per month.

- FDA-approved female generic over-the-counter (OTC) contraceptives. Coverage is limited to one per day and a 30 day supply per **prescription**.

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

Important Note:
This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Important Note:
This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact your **physician** or Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

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; and
- The reversal of voluntary sterilization procedures, including any related follow-up care.

Additional Covered Medical Expenses

Family Planning Services - *Other*

Covered expenses include charges for certain family planning services, even though not provided to treat an **illness** or **injury**.

- Voluntary termination of pregnancy. and
- Voluntary sterilization for males.

Limitations:
Not covered are:

- Male contraceptive methods or devices;
- Reversal of voluntary sterilization procedures, for males and females, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a **hospital** or other facility for medical care.

Important Notes:

1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Family Planning Services - Other*.
2. For more information, see the sections on *Family Planning Services - Female Contraceptives*, *Pregnancy Expenses* and *Treatment of Infertility* in this Booklet-Certificate.

Vision Care Benefits

Pediatric Routine Vision Exams
Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction and glaucoma testing.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

Pediatric Vision Care Services and Supplies
Covered expenses include charges for the following vision care services and supplies:

- Eyeglass frames, **prescription** lenses or **prescription** contact lenses identified by a vision **network provider**.

Coverage includes charges incurred for:

- Non-conventional **prescription** contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic **prescription** lenses prescribed after cataract surgery has been performed. Low vision services.

This benefit is subject to an age limit as shown on the *Schedule of Benefits*.

A listing of the locations of the vision **network providers** under this Plan can be accessed at the www.aetna.com website. Be sure to look at the appropriate vision **network provider** listing that applies to your plan, since different **Aetna** plans use different networks of providers. You must present your ID card to the vision **network provider** at the time of service.

This benefit is subject to the maximums shown on the Schedule of Benefits. As to coverage for **prescription** lenses in a calendar year, this benefit will cover either **prescription** lenses for eyeglass frames or **prescription** contact lenses, but not both.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses.
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes.

Important Notes:
Refer to the *Schedule of Benefits* for any cost-sharing, age limits, exam frequency limits and maximums that apply to vision exams, services and supplies.

Physician Services

Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician**'s office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

Important Reminder:
For a description of the preventive care expenses covered under this Plan, refer to the *Preventive Care Benefits* section in this Booklet-Certificate.

Surgery

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

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Important Reminder
Certain procedures need to be **precertified** by **Aetna**. Refer to *How Your Medical Plan Works* for more information about **precertification**.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by **walk-in clinics** for:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity;
  - in developing and maintaining a healthy diet;
  - in stress management.

  The stress management counseling sessions will:

- help you to identify the life events which cause you stress (the physical and mental strain on your body.); and
- teach you techniques and changes in behavior to reduce the stress.

Limitations:
Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished in a group setting for screening and counseling services.

Important Reminder:
- Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products, healthy diet and to aid in weight reduction due to obesity, refer to the *Preventive Care Benefits* section in this Booklet-Certificate and the *Screening and Counseling Services* benefit for a description of these services.
- These services may also be obtained from your **physician** or **PCP**.

E-Visits

Covered expenses include charges made by your **physician** or **PCP** for a routine, non-emergency, medical consultation. You must make your **E-visit** appointment through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetna.com or by calling the number on your identification card.

Telemedicine

Covered expenses include charges made by a **physician** or other health care provider for medical services associated with Telemedicine.

Telemedicine: The practice of health care delivery, diagnosis, consultation, and treatment of a covered **illness** or **injury** by way of the transfer of medical data by electronic means including audio, video, or data communications.

Covered expenses do not include charges made:

- for the delivery of health care services through, or for the use of telephone, e-mail, transmissions, facsimile transmissions, unsecured mail or any combination of these items; or
- for charges made by more than one health care provider for Telemedicine provided in connection with any one episode of treatment of a covered **illness** or **injury**.
- for Telemedicine performed by any provider who is not appropriately licensed by the State of Georgia.
- Data transmission fees.

Hospital Expenses

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

Room and Board

Covered expenses include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital**'s **semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;

- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

Covered expenses include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Outpatient Hospital Expenses

Covered expenses include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

Important Reminders
The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

Hospital admissions need to be **precertified** by **Aetna**. Refer to *How Your Medical Plan Works* for details about **precertification**.

Refer to the *Schedule of Benefits* for details about any cost-sharing and benefit maximums.

Coverage for Emergency Medical Conditions

Covered expenses include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** or **PCP** after receiving treatment for an **emergency medical condition**.

Important Reminder
With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care facility** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your **physician**;
- Use of **urgent care facilities**;
- **Physician** services;
- Nursing staff services; and
- Radiologist and pathologist services.

Please contact your **physician** or **PCP** after receiving treatment of an **urgent condition**.

If you visit an **urgent care facility** for a non-**urgent condition**, the plan will not cover your expenses, as shown in the *Schedule of Benefits*.

Pregnancy Expenses

Covered expenses include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness** or **injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

Note: **Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

Birthing Center Facility and Physician's Expenses

Covered expenses include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Limitations

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

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to pregnancy and childbirth services and supplies.

Important Reminder:
Certain prenatal care services are considered "Preventive Care". Refer to the *Prenatal Care* benefit under the Preventive Care section of this Booklet-Certificate for details.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician**'s or **dentist**'s office.

Important Note
Benefits for surgery services performed in a **physician**'s or **dentist**'s office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital**, **surgery center** on the day of the procedure;
- The operating **physician**'s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

Home Health Care

Covered expenses include charges for home health care services when ordered by a **physician** as part of a home health plan and provided you are:

- Transitioning from a **hospital** or other inpatient facility, and the services are in lieu of a continued inpatient **stay**; or
- **Homebound**

Covered expenses include only the following:

- **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than -4 hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (3 visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
    - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
    - The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
    - You are **homebound** because of **illness** or **injury**.
    - The services provided are not primarily for comfort, convenience or custodial in nature.
    - The services are intermittent or hourly in nature.

Home Health Care:

Benefits for home health care visits are payable up to the Home Health Care Maximum**.** Each visit by a nurse, **behavioral health provider** or therapist is 1 visit.

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist , up to 4 hours is 1 visit and
- **behavioral health provider,** of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an **R.N.** or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Important Note
Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation and Habilitation Therapies sections of the *Schedule of Benefits*.

Limitations

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

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.

- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation and Habilitation Therapies sections for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care.**

Important Reminders
The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Home health care needs to be **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

Skilled Nursing Facility

Covered expenses include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room** and **board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

Important Reminder
Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

This plan covers home short-term physical, speech, or occupational therapy when the above skilled nursing facility criteria are met. The *Short Term Rehabilitation* and *Habilitation Therapy Services* sections list the conditions and limitations for certain services.

Admissions to a **skilled nursing facility** must be **precertified** by **Aetna**. Refer to *Using Your Medical Plan* for details about **precertification**.

Limitations

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

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
  - Daily **room and board** charges over the **semi-private rate**.

Hospice Care

Covered expenses include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

Facility Expenses

The charges made by a **hospital**, **hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Covered expenses also include charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

Limitations

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

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

Inpatient **hospice care** and home health care must be **precertified** by **Aetna**. Refer to *How Your Medical Plan Works* for details about **precertification**.

Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed as a form of anesthesia in connection with covered surgical procedure.

Ambulance Service

Covered expenses include charges made by a professional **ambulance**, as follows:

Ground Ambulance

Covered expenses include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a **hospital** by air or water **ambulance** when:

- Ground **ambulance** transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one **hospital** to another **hospital**; when the first **hospital** does not have the required services or facilities to treat your condition and you need to be transported to another **hospital**; ***and*** the two conditions above are met.

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician**, **hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work

Covered expenses include charges for lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician**, **hospital** or licensed radiological facility or lab.

Outpatient Diagnostic Radiological Services

Covered expenses include charges for radiological services (other than complex imaging services), provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The services must be provided by a **physician**, **hospital** or licensed radiological facility.

Important Reminder
Refer to the *Schedule of Benefits* for details about any cost-sharing or benefit maximums that may apply to outpatient diagnostic testing, lab services and radiological services.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital**, **surgery center**, **physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will ***not*** be covered.

Important Reminder
Complex Imaging testing for preoperative testing is covered under the *Diagnostic Complex Imaging Expense* section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a **DME** supplier for the rental of equipment or, in lieu of rental:

The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet-Certificate. **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**.

Important Reminder
Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment** cost-sharing and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by **illness**, **injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

Limitations

The plan will not cover expenses and charges for, or expenses related to:
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the *Exclusions* section.

Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services

Covered expenses include charges made by a **hospital** for short-term rehabilitation therapy services, as described below, when prescribed by a **physician**. The services have to be performed by:

- A licensed or certified physical or occupational therapist; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac Rehabilitation Benefits

The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician.

Pulmonary Rehabilitation Benefits

Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A course of outpatient pulmonary rehabilitation appropriate for your condition is covered for the treatment of reversible pulmonary disease states.

Limitations

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

- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Services provided by a **physician** or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner.

Short-Term Rehabilitation Services

Covered expenses include charges for short-term rehabilitation services, as described below, when prescribed by a **physician** up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital**, **skilled nursing facility**, or **hospice facility**;
- A **home health care agency**; or
- A **physician**.

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your **physician,** that:

- Details the treatment, and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are homebound.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Except for physical therapy, occupational therapy of speech therapy provided for the treatment of Autism Spectrum Disorder, coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy is covered for non-chronic conditions and acute **illness** and **injuries**, provided that the therapy is expected to:
  - significantly improve, develop or restore physical functions lost; or
  - improves any impaired function.

  As a result of an acute **illness**, **injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy, (except for vocational rehabilitation or employment counseling), is covered for non-chronic conditions and acute **illness** and **injuries**, provided that the therapy is expected to:
  - significantly improve, develop or restore physical functions lost as a result of an acute **illness**, **injury** or surgical procedure; or
  - improve an impaired function as a result of an acute **illness**, **injury** or surgical procedure; or
  - to relearn skills to significantly improve independence in the activities of daily living.

  Occupational therapy does not include educational training.
- Speech therapy is covered for non-chronic conditions and acute **illness** and **injuries**, provided that the therapy is expected to:
  - significantly improve or restore the speech function or correct a speech impairment resulting from **illness, injury** or surgical procedure; or
  - improve delays in speech function development as a result of a gross anatomical defect present at birth.

  Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Spinal Manipulation Treatment

Covered expenses include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your **provider** must establish or approve a treatment plan that details the treatment, and specifies frequency and duration.

Habilitation Therapy Services

Covered expenses include **habilitation** therapy services your **physician** prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A **hospital**, **skilled nursing facility**, or **hospice facility**
- A **home health care agency**
- A **physician**

Habilitation therapy services have to follow a specific treatment plan, ordered by your **physician**, that:

- Details the treatment, and specifies frequency and duration, and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
- Allows therapy services, provided in your home, if you are homebound

Covered expenses include:

- Physical therapy, if it is expected to develop any impaired function
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your independence in the activities of daily living
- Speech therapy is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development

  (Speech function is the ability to express thoughts, speak words and form sentences).

Limitations

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

- Educational services for Down's Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a **stay** in a **hospital**, **skilled nursing facility, home health agency**, or **hospice facility except as stated above**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a **physician**, **hospital**, or **surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - the defect results in severe facial disfigurement, or
  - the defect results in significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Important Notice
A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits.*

Clinical Trial Therapies (Experimental or Investigational Treatment)

Covered expenses include charges made by a **provider** for **experimental or investigational** drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a **terminal illness**, and ***all*** of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets all of these criteria;

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to the standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine Patient Costs

Covered expenses include charges made by a **provider** for "routine patient costs" furnished to you in connection with your participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Coverage is limited to benefits for routine patient services provided within the network.

Limitations:

Not covered under this Plan are:

Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);

- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising **experimental** or **investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Important Notes:
1. Refer to the *Schedule of Benefits* for details about cost sharing and any benefit maximums that apply to the *Clinical Trial* benefit. 2. These *Clinical Trial* benefits are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to, any **precertification** requirements.

Outpatient Therapies

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including but is not limited to:

- A free-standing outpatient facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.Aetna.com or calling the number on the back of your ID card.

Infusion therapy is the intravenous administration of prescribed medications or solutions.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan or this certificate.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Limitations

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

Important Reminders

Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance**, or benefit maximum that apply.

Specialty care prescription drugs

Covered expenses include **specialty care prescription drugs** when they are:

- Purchased by your **provider,** and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in his/her office
  - A home care **provider** in your home
- And, listed on our **specialty care prescription drug** list as covered under this certificate.

Certain infused medications may be covered under the **prescription drug plan**. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan or Booklet-Certificate.

In-Hospital Dental Procedures Benefit

Covered expenses include charges for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care provided if the covered person is:

- 7 years of age or younger or is developmentally disabled;
- an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or
- an individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation.

Diabetes Benefits

Covered expenses include charges for the following services, supplies, equipment, and training for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy:

Services and Supplies:

- Foot care to minimize the risk of infection;
- Insulin preparations;
- Diabetic needles and syringes;
- Injection aids for the blind;
- Diabetic test agents;
- Lancets/lancing devices;
- Prescribed oral medications whose primary purpose is to influence blood sugar;
- Alcohol swabs;
- Injectable glucagons; and
- Glucagon emergency kits.

Equipment:

- External insulin pumps; and
- Blood glucose monitors without special features unless required due to blindness.

Training:

- Self-management training provided by a licensed health care provider certified in diabetes self-management training.

Basic Infertility Expenses

Covered expenses include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

Autism Spectrum Disorder

Covered expenses include charges for the diagnosis and treatment of Autism Spectrum Disorder (including Applied Behavioral Analysis) in covered individuals from age six and under. Treatment of autism spectrum disorder shall be identified in a treatment plan and includes the following care prescribed or ordered for a covered individual diagnosed with autism spectrum disorder by a licensed **physician**, or a licensed psychologist who determines the care to be **medically necessary**: (i) behavioral therapy, (ii) habilitative and rehabilitative services, (iii) counseling services, (iv) therapy services, (v) prescription drugs, and (vi) applied behavioral analysis.

Coverage for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders is not subject to a limit on the number of visits.

Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism Spectrum Disorders means any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Jaw Joint Disorder Treatment

The plan covers charges made by a **physician**, **hospital** or **surgery center** for the diagnosis, surgical and non-surgical treatment of **jaw joint disorder**. A **jaw joint disorder** is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- 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).

The **network** level of benefits is paid only for a treatment received at a facility designated by the plan as an **Institute of Excellence™ (IOE)** for the type of transplant being performed. Each **IOE** facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an **IOE** for the transplant being performed will be covered as **out-of-network** services and supplies, even if the facility is a **network** facility or **IOE** for other types of services.

The plan covers:

- 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 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.
- 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 parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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 180 days from the date of the transplant; ***or*** 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:

- 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;
- Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
- 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; and
- 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.

If you are a participant in the **IOE** program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any **covered expenses** you incur from an **IOE** facility will be considered network care expenses.

Important Reminders
To ensure coverage, all transplant procedures need to be **precertified** by **Aetna**. Refer to the *How Your Medical Plan Works* section for details about **precertification**.

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- 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;
- Services and supplies furnished by a non-**IOE** facility.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities
Through the **IOE** network, you will have access to a provider network that specializes in transplants. Benefits may vary if an **IOE** facility or non-**IOE** or **out-of-network provider** is used. In addition, some expenses are payable only within the **IOE** network. The **IOE** facility must be specifically approved and designated by **Aetna** to perform the procedure you require. Each facility in the **IOE** network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when ***not*** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

- Natural teeth damaged, lost, or removed; or
- Other body tissues of the mouth fractured or cut

due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

Treatment of Mental Disorders

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **mental disorders** as follows:

- **Inpatient room and board** at the **semi-private room rate,** and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility** including:

  - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a **physician.**
  - Office Visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health professionals.

Important Reminders

Please refer to the *E-visits* section for information about **covered expenses** for **e-visits**.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Exclusions* section for more information.

Inpatient and certain outpatient treatments must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for more information about **precertification**.

Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums and **coinsurance limits** that may apply to your **mental disorder** benefits.

Treatment of Substance Abuse

Covered expenses include charges made by a **hospital**, **psychiatric hospital**, **residential treatment facility** or **behavioral health provider** for the treatment of **substance abuse** as follows:

- **Inpatient room and board** at the **semi-private room rate** and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital** or **residential treatment facility.** Treatment of substance abuse in a general medical **hospital** is covered only when you are admitted to the **hospital's** separate **substance abuse** section or unit for treatment of medical complications of **substance abuse**.

As used here, "medical complications" include, but are not limited to, **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital** or **residential treatment facility** including:

  - **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a **physician**. The facility or program does not make a **room and board** charge for the treatment.
  - Intensive Outpatient Program (at least 2 hours per day and at least six hours per week of clinical treatment) provided in a facility or program under the direction of a **physician.**
  - Office visits to a **physician (**such as a **psychiatrist)**, psychologist, social worker, or licensed professional counselor, as well as other health care professionals.

Important Reminders
Please refer to the *E-visits* section for information about **covered expenses** for **e-visits**.

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Exclusions* section for more information.

Inpatient and certain outpatient treatments must be **precertified** by **Aetna**. Refer to *Understanding Medical Precertification* for more information about **precertification**.

Please refer to the *Schedule of Benefits* for any **copayments**/**deductibles**, maximums and **coinsurance limits** that may apply to your **substance abuse** benefits.

Pediatric Dental Benefits

What the Dental Benefit Covers

Pediatric Dental Services

Covered expenses include charges made by a **dental provider,** who is a **network provider,** for the dental services listed in the Pediatric Dental Care Schedule below and provided to covered persons through the end of the month in which the person turns 19.

The plan does not pay a benefit for all dental care expenses that you incur.

Important Reminder:

Your dental services and supplies must meet the following rules to be covered by the plan:

- The services and supplies must be **medically necessary**.
- The services and supplies must be covered by the plan.
- You must be covered by the plan when you incur the expense.

About the PPO Dental Expense Insurance Plan

The plan is a Preferred Provider Organization (PPO) Dental Expense Insurance Plan that covers a limited range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a **network provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more out of your own pocket when you choose an **out-of-network provider**.

The *Schedule of Benefits* shows you how the Plan's level of coverage is different for **network services and supplies** and **out-of-network services and supplies**.

The Choice Is Yours

You have a choice each time you need dental care:

Using Network Providers

- You will receive the Plan's higher level of benefits when your care is provided by a **network provider**.
- The plan begins to pay benefits after you satisfy a **deductible**.
- You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**). **Network providers** have agreed to provide covered services and supplies at a **negotiated charge.** Your **coinsurance** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply.
- You will not have to submit dental claims for treatment received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles, coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible, copayment, coinsurance**, or other non-**covered expenses** you have incurred. You may elect to receive this notification by e-mail, or through the mail. Contact Member Services by logging onto the Aetna website www.aetna.com, or calling the toll-free number on the back of your ID card if you have questions regarding your statement.

Availability of Providers

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

Using Out-of-Network Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers **out-of-network services and supplies**, but your expenses will generally be higher.

Out-of-network providers have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Deductibles** and **coinsurance** are usually higher when you utilize **out-of network providers.** Except for emergency services, **Aetna** will only pay up to the **recognized charge**.

You must satisfy a **deductible** before the plan begins to pay benefits.

You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).

Pediatric Dental Care Schedule

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition;

then the charge will be considered to have been made for a service in the list that **Aetna** determines would have produced a professionally acceptable result.

The Pediatric Dental Care Schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Diagnostic and Preventive Care

- Basic Restorative Care
- Major Restorative Care
- Orthodontic Care

These covered services and supplies are grouped as Type A, Type B, Type C and Orthodontic Expenses. Please refer to the *Schedule of Benefits* for more information.

Coverage is also provided for a **dental emergency**. Services provided for a **dental emergency** will be covered at the network level of benefits even if services and supplies are not provided by a **network provider**. For additional information, please refer later in this *Booklet-Certificate* to the *In Case of a Dental Emergency* section.

Important Note:

The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than$300. Ask your **dentist** to write down a full description of the treatment you need, using either an **Aetna** claim form or an ADA approved claim form. Then, before actually treating you, your **dentist** should send the form to **Aetna**. **Aetna** may request supporting images and other diagnostic records. Once all of the information has been gathered, **Aetna** will review the proposed treatment plan and provide you and your **dentist** with a statement outlining the benefits payable by the plan. You and your **dentist** can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your **dentist** can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups.

In determining the amount of benefits payable, **Aetna** will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result. (See the *Alternate Treatment Rule* later in this *Booklet-Certificate* for more information on alternate dental procedures.)

What Is a Course of Dental Treatment?

A course of dental treatment is a planned program of one or more services or supplies. The services or supplies are provided by one or more **dentists** to treat a dental condition that was diagnosed by the attending **dentist** as a result of an oral examination. A course of treatment starts on the date your **dentist** first renders a service to correct or treat the diagnosed dental condition.

In Case of a Dental Emergency

If you need dental care for the palliative treatment (e.g., pain relieving, stabilizing) of a **dental emergency**, you are covered 24 hours a day, 7 days a week.

A **dental emergency** is any dental condition which:
- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

Follow the guidelines below when you believe you have a **dental emergency**.

If you have a **dental emergency**, you may get treatment from any **dentist**. You should consider calling your dental **network provider,** if possible. Your dental **network provider** may be more familiar with your dental needs. If you are not able to reach your **network dental provider** or you are away from home, you may get treatment from any **dentist**.

You may also call **Aetna** Member Services at the toll-free telephone number on your ID Card for help in finding a **dentist**.

The care received from a dental **out-of-network provider** must be for the temporary relief of a **dental emergency** until you can be seen by your dental **network provider**. Care received from a dental **out-of-network provider** for other than the temporary relief of the **dental emergency** may cost you more. To receive the maximum level of benefits, care should be provided by a dental **network provider.**

The plan pays a benefit up to the **Dental Emergency** Maximum, shown in the *Schedule of Benefits.*

What does the Plan pay When You Go to an Out-of-Network Provider for a Dental Emergency?

The network level of coverage applies for services and supplies received from a dental **out-of-network provider** for the temporary relief of a **dental emergency.** The dental **out-of-network provider** may ask you for full payment at the time treatment is given. The care provided must be a covered service or supply. You must submit a claim for reimbursement to **Aetna** describing the care given by a **dental out-of-network provider** in order to receive reimbursement. Reimbursement will be based upon the network covered amount according to the Type of dental expense, as shown in the *Schedule of Benefits*, up to the **Dental Emergency** Maximum. You are responsible for charges above the **Dental Emergency** Maximum.

Additional dental care to treat the dental condition after the **dental emergency** has been stabilized will be covered at the appropriate **coinsurance** level depending upon where you receive service. If you use a dental **network provider** for follow-up care, the network level of benefits applies.

Rules and Limits That Apply to the Dental Benefits

Several rules apply to the dental benefits. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

Waiting Period

The plan has a waiting period for **orthodontic treatment** as follows:

- **Orthodontic treatment**: Your coverage will take effect after 24 months of continuous coverage under the Plan.

Orthodontic Treatment Rule

Orthodontic treatment is covered when it is **medically necessary** for a covered person with a severe, dysfunctional, handicapping condition such as:

(A) Cleft lip and palate, cleft palate, or cleft lip with alveolar process involvement

(B) The following craniofacial anomalies:

- Hemifacial microsomia;
- Craniosynostosis syndromes;
- Cleidocranial dental dysplasia;
- Arthrogryposis; or
- Marfan syndrome

(C) Anomalies of facial bones and/or oral structures

(D) Facial trauma resulting in functional difficulties

Reimbursable orthodontic services include:

- pre-orthodontic treatment visit
- comprehensive orthodontic treatment

- orthodontic retention (removal of appliances, construction and placement of retainers(s)

This benefit does not cover charges for the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
- Removable acrylic aligners (i.e. "invisible aligners").

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to **Aetna** that:

- You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
- Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 5 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment; and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your **dental provider**. Of course, you and your **dental provider** can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30days after your coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

Jaw Joint Disorder Treatment Rule

Coverage for **Jaw Joint Disorder** treatment is covered as a Type C Service. This includes treatments which alter the jaw, jaw joints, or bite relationships. The following are covered:

- Diagnosis;
- Applicable therapy; and
- Other non-surgical treatment.

Not included are charges incurred for:

- Orthodontic treatment;
- Crowns, bridges and dentures;
- Treatment of periodontal disease;
- Implants; and
- Root canal therapy.

Pediatric Dental Plan Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dental provider**. The plan covers only those services and supplies that are **medically necessary**. Charges made for the following are not covered except to the extent listed under the *What the Medical Benefit Covers* section of the *Booklet-Certificate* or by amendment attached to this *Booklet-Certificate*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These dental exclusions are in addition to the exclusions that apply to health coverage.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Medical Benefit Covers* section of the *Booklet-Certificate*.

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in the *Booklet-Certificate*.

- Any instruction for diet, plaque control and oral hygiene.

- Any non-emergency charges for **covered expenses** incurred outside of the United States.

- Charges submitted for services:
  - By an unlicensed **hospital**, **physician** or other provider; or
  - By a licensed **hospital**, **physician** or other provider that are not within the scope of the provider's license.

- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan.

- **Cosmetic** services and supplies including plastic surgery, reconstructive surgery, **cosmetic** surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Medical Benefit Covers* section of the Policy. Facings on molar crowns and pontics will always be considered **cosmetic**.

- Court ordered services, including those required as a condition of parole or release.

- Crown, inlays and onlays, and veneers unless:
  - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
  - The tooth is an abutment to a covered partial denture or fixed bridge.

- Dental Examinations that are:
  - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
  - Any special medical reports not directly related to treatment except when provided as part of a covered service.
- Dental implants and braces (that are determined not to be **medically necessary**), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

- Dental services and supplies that are covered in whole or in part under any other part of this plan.

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

- Except as covered in the *What the Medical Benefit Covers* section of the *Booklet-Certificate*, treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

- **Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Medical Benefit Covers* section of the *Booklet-Certificate*.

- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another **medically necessary** covered service or supply.

- Medicare: Payment for that portion of the charge for which Medicare is the primary payer.

- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a **physician's** practice;
  - Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:

    Care in charitable institutions;

Care for conditions related to current or previous military service;

Care while in the custody of a governmental authority;

Any care a public **hospital** or other facility is required to provide; or

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

- Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

- **Orthodontic treatment** except as covered in *Orthodontic Treatment Rule* section of the *Booklet-Certificate*.

- Pontics, crowns, cast or processed restorations made with high noble metals (gold).

- Prescribed drugs; pre-medication; or analgesia.

- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

- Replacement of teeth beyond the normal complement of 32.

- Routine dental exams and other preventive services and supplies, except as specifically provided in the Pediatric Dental Benefit section and in the *What the Medical Benefit Covers* section of the *Booklet-Certificate*.

- Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

- Services and supplies provided in connection with treatment or care that is not covered under the plan.

- Services rendered before the effective date or after the termination of coverage.

- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

- Surgical removal of impacted wisdom teeth only for orthodontic reasons.

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
  - Scaling of teeth;
  - Cleaning of teeth; and
  - Topical application of fluoride.

- Work related: Any **illness** or **injury** related to employment or self-employment including any **injuries** that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an **occupational illness** or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular **illness** or **injury** under such law, that **illness** or **injury** will be considered "non-occupational" regardless of cause.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dental provider**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this *Booklet-Certificate*.

Important Reminder:
You have medical, dental and prescription drug insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific dental and prescription drug coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: 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.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.

Any non-emergency charges for **covered expenses** incurred outside of the United States

Applied Behavior Analysis and similar programs unless specifically described in the *What the Medical Benefit Covers* section.

Behavioral health services that are not primarily aimed at treatment of **illness**, **injury**, restoration of physiological functions or that do not have a physiological or organic basis.

Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **network provider** in excess of the **negotiated charge**.

Charges for a service of supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Clinical trial therapies

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental and investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies).

Contraception, except as specifically described in the *What the Plan Covers* section including, but not limited to, over the counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants);
- Removal of tattoos;
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation; and
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Court ordered services, including those required as a condition of parole or release.

Custodial Care

Dental Services: Except as specifically covered in the *What the Plan Covers* section, any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies, except as specifically described in the *What the Plan Covers* Section:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-**covered expenses**;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drug**s;
- Self-injectable **prescription drug**s and medications;

- Any **prescription drug**s, injectables, or medications or supplies provided by the employer or through a third party vendor contract with the employer; and
- Any expenses for **prescription drugs**, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

Any:
- health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel; and
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity.
- special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or investigational drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: Except as specifically covered in the *What the Plan Covers* section, any food item, including infant formulas, nutritional supplements, vitamins, including **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Habilitation Therapy Services -- Physical, Occupational and Speech Therapy Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth, including:

- Therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Pervasive developmental disorders
  - Down syndrome
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.

This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder.

Hearing: Related services and supplies, except as specifically described in the *What the Plan Covers* Section:

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds. and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;

- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.

Mental health treatment

Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):

- Dementias and amnesias without behavioral disturbances
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders
- Specific disorders of sleep
- Antisocial or dissocial personality disorder
- Pathological gambling, kleptomania, pyromania
- Specific delays in development (learning disorders, academic underachievement)
- Intellectual disability
- Wilderness Treatment Programs or any such related or similar programs, school and/or education services.

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness**, **injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Outpatient prescription contraceptive drugs and devices

- Oral drugs that are **brand-name prescription drugs** and **biosimilar prescription drugs**.
- Injectable drugs that are **brand-name prescription drugs** and **biosimilar prescription drugs**.
- Vaginal rings that are **generic prescription drugs**, **brand-name prescription drugs** and **biosimilar prescription drugs**.

- Transdermal contraceptive patches that are **generic prescription drugs**, **brand-name prescription drugs** and **biosimilar prescription drugs**.
- FDA-approved female brand-name and biosimilar emergency contraceptives and brand-name over-the-counter (OTC) emergency contraceptives.
- Other FDA-approved female and male brand-name over-the-counter (OTC) contraceptives.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital** and outpatient private duty nursing services.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate.

Short-Term Rehabilitation Services -- Outpatient Cognitive Rehabilitation, Physical, Occupational and Speech Therapy Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth, including:

Therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:

- Down syndrome
- Cerebral palsy

- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **Home Health Care Agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
    - Services not given by a **Physician** (or under the direct supervision of a **Physician**), physical, occupational or speech therapist.

This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in *What the Plan Covers* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed. This exclusion does not apply to speech therapy provided for the treatment of Autism Spectrum Disorder.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses**, **injuries** or disabilities related to the use of performance-enhancing drugs or preparations.

Substance Abuse Treatment: Except as provided in the *What the Medical Benefit Covers s*ection, alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis.

Telemedicine: Any services that are given by **providers** that are not contracted with **Aetna** as **telemedicine providers**. Any services that are provided other than during an internet-based consult or via telephone.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered except as specifically described in the *What the Plan Covers* Section. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically described in the *What the Plan Covers* Section.

Transplant-Related Services: 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 the recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/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 **precertified** by **Aetna**;

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a covered person without **Precertification** by **Aetna** when required. This exclusion does not apply in a medical emergency or in an urgent care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section.

In addition, the plan does not cover:

- Special supplies such as non-**prescription** sunglasses;
- Vision service or supply which does not meet professionally accepted standards;
- Special vision procedures such as orthoptics or vision training;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions, except as specifically described in the *What the Plan Covers* Section, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or

reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

Your Pharmacy Benefit

How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

A few important notes to consider before moving forward:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet-Certificate as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet-Certificate in a safe place for future reference.

Notice
The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet-Certificate.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your *Schedule of Benefits*
- **Specialty prescription drug** refills will only be covered when obtained through **Aetna's specialty network pharmacy**.

This plan covers only certain **prescription drugs** in accordance with the plan and the **preferred drug guide (formulary)**. This plan does not cover all **prescription drugs**.

Getting Started: Common Terms

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

Brand-Name Prescription Drug is a U.S. Food and Drug Administration (FDA) approved **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medi-Span or similar publication designated by **Aetna**.

Generic Prescription Drug is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medi-span or similar publication designated by **Aetna**.

Network pharmacy is a retail **pharmacy**, **mail order pharmacy** or **specialty network pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, to furnish services and supplies for this plan. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. retail **network pharmacy,** mail order **network pharmacy** or **specialty network pharmacy**).

Non-Preferred Drug (Non-Formulary) is a **prescription drug** or device that is not listed in the **preferred drug guide (formulary)**. This includes **prescription drugs** and devices on the **preferred drug guide exclusions list** that are approved by medical exception.

Out-of-network pharmacy is a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor, and does not participate in the **pharmacy** network.

Preferred Drug (Formulary) is a **prescription drug** or device that is listed on the **preferred drug guide (formulary)**.

Preferred Drug Guide (Formulary) is a listing of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide (formulary)** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com.

Preferred Drug Guide Exclusions List is a list of **prescription drugs** and devices in the **preferred drug guide (formulary)** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna** or an affiliate.

Prescription Drug is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services within the scope of their license.

Self-injectable Drug(s) are **prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Specialty Network Pharmacy is a network of **pharmacies** designated to fill **prescriptions** for **self-injectable drugs** and **specialty care drugs**.

Accessing Pharmacies and Benefits

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. Aetna has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Read to your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you and any per prescription or refill dollar maximums that may apply.

To better understand the choices that you have with your plan, please carefully review the following information.

Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna's** website at www.aetna.com. You can search **Aetna**'s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area call Member Services.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network **benefits**. The **network pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any **network retail pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the prescription and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing.

Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.

- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

When You Use an Out-of-Network Pharmacy

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

What the Pharmacy Benefit Covers

The plan covers charges for outpatient **prescription drugs** for the treatment of an **illness** or injury (including inhalants), subject to the Limitations section of this coverage and the *Medical Benefit* and *Pharmacy Benefit* Exclusions sections of the Booklet-Certificate. Prescriptions must be written by a **prescriber** licensed to prescribe federal legend prescription drugs.

This plan covers only certain **prescription drugs** in accordance with the plan and the **preferred drug guide (formulary)**. This plan does not cover all **prescription drugs**.

Your **prescription drug** benefit coverage is based on **Aetna's preferred drug list**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug list**.

Preferred generic prescription drugs may substituted by your pharmacist for **brand-name prescription drugs** or **biosimilar prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Your prescription drug benefits coverage is based on Aetna's **preferred drug guide (formulary)**. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferr **preferred drug guide (formulary).**

Your **prescription drug** benefit may be subject to pharmacy management programs including, but not limited to **precertification**, **step therapy,** quantity limits and drug utilization review. Refer to *Understanding Pharmacy Precertification* for further information.

Coverage of **prescription drugs** may, in **Aetna**'s sole discretion, be subject to **precertification**, **step therapy** or other **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by **Aetna**, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs** prescribed by a specific **provider**. Such limitation may be enforced in the event that **Aetna** identifies an unusual pattern of claims for **covered expenses.**

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **retail pharmacy**. Each **prescription** is limited to the maximums shown in the *Schedule of Benefits***.**

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are **covered** when dispensed by a **mail order pharmacy** that is a **network pharmacy**. Each **prescription** is limited to a maximum 90-day supply. **Prescriptions** less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a **mail order pharmacy** that is a **network pharmacy**.

See the *Schedule of Benefits* for details on supply limits and cost sharing.

After you obtain your second fill at a **network retail pharmacy** you must notify us of whether you want to use your mail order pharmacy benefit or continue to obtain your **prescriptions** at a **network retail pharmacy** by calling the number on the back of your ID card. If you fail to inform us of your choice, then the next **prescription** refill (and any subsequent refills) at a **network retail pharmacy** will not be covered.

You may contact us at any time to let us know that you intend to use a **network retail pharmacy** for future **prescription** refills.

Specialty Care Prescription Drug Benefits

Network Benefits

Specialty care prescription drugs (specialty care drugs) are covered when dispensed through a retail **network pharmacy** or a **specialty network pharmacy**. **Specialty care prescription drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to **Aetna's** website, www.aetna.com, to review the list of covered **specialty care prescription drugs** through a retail **network pharmacy** or a **specialty pharmacy network pharmacy**. The list may be updated from time to time.

Out-of-Network Benefits

Specialty care prescription drugs are covered at the **out-of-network** level of benefits when obtained from an **out-of-network pharmacy**.

Refer to **Aetna's** website, www.aetna.com to review the list of covered **specialty care prescription drugs.** The list may be updated from time to time.

Over-the-Counter Prescription Drug Benefit

Over-the-counter medications, as determined by the plan may be covered in an equivalent prescription dosage strength for the appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto www.aetna.com.

Orally administered anti-cancer drugs, including chemotherapy drugs.

Orally administered anti-cancer drugs, including chemotherapy drugs may be covered when the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.

Other Covered Pharmacy Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

Off-Label Use

FDA-approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your symptom(s) subject to the following:

- The drug must be accepted as safe and effective to treat your symptom(s) in one of the following standard compendia:
  - American Society of Health-System Pharmacists Drug Information (AHFS Drug Information);
  - Thomson Micromedex DrugDex System (DrugDex);
  - Clinical Pharmacology (Gold Standard, Inc.); or
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your symptom(s) has been proven as safe and effective by at least one well-designed controlled clinical trial. Such a trial must be published in a peer reviewed medical journal known throughout the U.S. and either:
  - the dosage of a drug for your symptom(s) is equal to the dosage for the same symptom(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above; or
  - the dosage has been proven to be safe and effective for your symptom(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Coverage of off-label use of these drugs may, in Aetna's discretion, be subject to **precertification**, **step therapy** or other requirements or limitations.

Diabetic Supplies

Covered expenses include, but are not limited to the following diabetic supplies upon prescription by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered expenses include charges made by a **network pharmacy** or **out-of-network pharmacy** for the following FDA approved contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs**, **brand-name prescription drugs** and **biosimilar prescription drugs**.
- Female contraceptives that are generic **prescription** and over-the-counter (OTC) emergency contraceptives that are shown on the **preferred drug list (formulary)**.
- Female contraceptive devices that are generic devices and brand-name devices.
- FDA-approved female:
  - Generic, brand-name and biosimilar emergency contraceptives; and
  - Generic and brand-name over-the-counter (OTC) emergency contraceptives obtained without a **prescription**.

  Coverage is limited to 1 emergency contraceptive(s) per month.
- FDA-approved female generic and brand-name over-the-counter (OTC) contraceptives;
-

Important Note:
This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive p**rescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

Refer to the *Copay and Deductible Waiver* section of your *Schedule of Benefits* for cost-sharing information.

Reimbursement of Contraceptives at an Out-of-Network Pharmacy

The FDA-approved contraceptives described above are covered under this Plan when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

You will be reimbursed by **Aetna** for the cost of the contraceptive when you submit proof of loss to **Aetna** that you purchased the contraceptive at an **out-of-network pharmacy**. "Proof of loss" means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (that is attached to the bag that contains the contraceptive).

Refer to the provisions *Reporting of Claims* and *Payment of Benefits* later in this Booklet-Certificate for information on submitting claims. You can also contact Member Services by logging onto the **Aetna** website at www. aetna.com or calling the toll-free number on the back of the ID card.

Important Notes:

1. The *Copay and Deductible Waiver* does not apply to contraceptive methods that are:
   - **Brand-name prescription drugs**;
   - FDA-approved female:
     - brand-name emergency contraceptives; and

   However, the *Copay and Deductible Waiver* does apply when:
   - such contraceptive methods are not available within the same **therapeutic drug class**; or
   - a generic equivalent, biosimilar or generic alternative, within the same **therapeutic drug class** is not available; and
   - you are granted a medical exception. Refer to *Medical Exceptions* described in the *Precertification* section for information on how you or your **prescriber** can obtain a medical exception.

2. A *generic equivalent* contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A *biosimilar* is a biological drug that is therapeutically similar to the **brand-name prescription drug**. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

Understanding Pharmacy Precertification

Precertification is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** or an affiliate to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and modification by **Aetna**. For the most up to date information, call the toll-free Member Serve number on your member ID card or log on to your Aetna Navigator secure member website and can be found in the **Aetna preferred drug guide** available online at www.aetna.com.

Failure to request **precertification** will result in reduction of benefits (see your *Schedule of Benefits*), or denial of coverage, so be sure to ask your **prescriber** or pharmacist if the drug being considered requires **precertification.**

How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

Aetna will let your **prescriber** know if the **prescription drug** is **precertified**.

If **precertification** is denied **Aetna** will notify you how the decision can be appealed.

Step Therapy

Step-therapy is another form of **precertification**. With **step-therapy**, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the **prescriber** obtains a medical exception.

Lists of the **step-therapy** drugs and prerequisite drugs are included in the **preferred drug guide (formulary)** available upon request or on your Aetna Navigator secure member website at www.aetna.com. The list of step therapy drugs are subject to change by **Aetna**.

Prescribing Units

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units dispensed per **prescription** order or refill. Drugs that are allowed to be filled with greater than 30 day supply are limited to 300 units dispensed per **prescription** order or refill.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

Specialty Care Prescription Drugs may have limited access or distribution and are limited to no more than a 30 day supply subject to supply limits.

Medical Exceptions

You or your **prescriber** may seek a medical exception to obtain coverage for drugs not listed on the **preferred drug guide (formulary)** or for which coverage is denied through **precertification** or **step therapy**. The **prescriber** must submit such exception requests to **Aetna**. **Aetna** will make a coverage determination within 72 hours after receipt of your request and will notify you and your designee and your prescriber of the decision. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons. If approved by **Aetna**, you will receive the non-**preferred drug** benefit level and the exception will be granted for the duration of the prescription.

You, your designee or your **prescriber** may seek an expedited medical exception process to obtain coverage for non-covered **prescription drugs** in exigent circumstances. An exigency exists when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a non-formulary drug. You, your designee, or your **prescriber** may submit a request for an expedited review for an exigency as described below by contacting **Aetna**'s Precertification Department at 1-855-582-2025, faxing the request to 1-855-330-1716 or submitting the request in writing to CVS Health ATTN: Aetna PA 1300 E Campbell Road Richardson, TX 75081. We will make a coverage determination within 24 hours after receipt of your request and will notify you or your designee and your **prescriber** of our decision. If approved by **Aetna** the exception will be granted for the duration of the exigency.

If you are denied a medical exception based on the above processes, you may have the right to a third party review by an independent external review organization. If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination we send you. That notice also will describe the external review process. We will notify you, your designee or your prescriber of the coverage determination of the external review no later than 72 hours after receiving your request. If the medical exception is approved, coverage will be provided for the duration of the prescription. For expedited medical exceptions in exigent circumstances, we will notify you, your designee or your **prescriber** of the coverage determination no later than 24 hours after receiving your request. If the expedited medical exception is approved, coverage will be provided for the duration of the exigency.

Pharmacy Benefit Limitations and Exclusions

Limitations

A **network pharmacy** may refuse to fill a **prescription** order or refill when in the professional judgment of the pharmacist the **prescription** should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

The number of **copayments** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dental provider** it may not be covered. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet-Certificate*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

Aetna reserves the right to include only one manufacturer's product on the **preferred drug list** when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

Aetna reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

Any charges in excess of the benefit, day, or supply limits stated in this Booklet-Certificate.

All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate. This also includes **prescription drugs** or supplies if:

- such prescription drug or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Any **prescription drug** or supply used for the treatment of sexual dysfunction/ enhancement in any form. Any **prescription drug** in any form that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar or identical outcomes.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that of a drug that is effective for three (3) months would require three (3) **copayments**.

Brand name prescription drugs and devices when a **prescription drug** or device equivalent, **biosimilar prescription drug** or **generic prescription drug** or device alternative is available, unless otherwise covered by medical exception.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

Certain **prescription drugs** but only to the extent such coverage is excluded under the plan and the **preferred drug guide (formulary)**.

Compound **prescription** will be subject to **non-preferred** cost sharing.

Contraceptives, except as specifically described in the *What the Medical Benefit Covers* and *What the Pharmacy Benefit Covers* sections including, but not limited to, over the counter contraceptive supplies such as condoms, contraceptive foams, jellies and ointments.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth and removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;

- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin vials, pens, cartridges, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill. Drugs that are allowed to be filled with greater than 30 day supply at a **retail pharmacy** are excluded from the 100 unit limitation dispensed per **prescription** order or refill.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by **Aetna's** Pharmacy and Therapeutic Committee.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Plan Covers* section.

Drugs that include vitamins and minerals, both over-the counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and
- other medications.

Drugs used for the treatment of obesity.

Drugs used for the treatment of sexual dysfunction/enhancement.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written.

Duplicative drug therapy (e.g. two antihistamine drugs).

Durable medical equipment, monitors and other equipment.

Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section.

This exclusion will not apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the illness.

Food items: Except as described in the *What the Medical Benefit Covers* section, any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents except as described in the *What the Plan Covers* section.

Immunizations related to travel or work.

Implantable drugs and associated devices, except for implantable contraceptives and as described in the *What the Plan Covers and What the Pharmacy Benefit Covers* sections.

Injectables or infused drugs, except for injectable generic contraceptives as described in the *What the Medical Benefit Covers and What the Pharmacy Benefit Covers* section.

- Any charges for the administration of an infused or injected **prescription drug** or injectable insulin and other infused or injected drugs covered by **Aetna**;
- Certain injectable agents such as injectable contrasts/dyes used for imaging (e.g., MRI, CT, Bone Scans), except insulin;
- Needles and syringes except diabetic needles and syringes, or for a covered drug;
- Injectable drugs if an alternative oral drug is available; and
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

Plan approved blood glucose meters, asthma holding chambers an peak flow meters are **eligible health services**, but limited to one (1) prescription order per **calendar year**.

Prescribed contraceptive diaphragms are limited to two (2) per **calendar year**.

Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient even if a **prescription** is written, unless **medically necessary**.

Prescription drugs, medications, injectables or supplies given through a third party vendor contract with the employer.

Prescription drugs dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe.

Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

Prescription drugs that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.

Prescription drugs that are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

Prescription drugs that are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.

Prescription drugs that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you. That are not considered covered or related to a non-covered service.

Prescription drugs that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet-Certificate.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescription**s.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your prescription drug is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.

Specialty care prescription drugs may have limited access or distribution and are limited to no more than a 30 day supply.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

Tobacco use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum, except as described in the *What the Plan Covers* section unless recommended by the United States Preventive Services Task Force (USPSTF).

When Coverage Ends

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

When Coverage Ends for Employees

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage under this Plan;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, **Aetna** may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:
  - If you are not actively at work due to **illness or injury**, your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
  - If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence.

It is your employer's responsibility to let **Aetna** know when your employment ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends for Employees* section;
- Your dependent is no longer eligible for coverage under this Plan. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership. In that event, you should provide your Employer a completed and signed Declaration of Termination of Domestic Partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage
Continuing Health Care Benefits

Continuing Coverage for Dependents After Your Death
If you should die while enrolled in this plan, your dependent's health care coverage (except dental coverage), if applicable will continue as long as:

- You were covered at the time of your death;
- Your dependent was covered at the time of your death;
- Your coverage, at the time of your death, is not being continued after your employment has ended, as provided in the *When Coverage Ends* section;
  You are survived by a spouse:
    who is continuing Health Expense Coverage in accordance with Continuation of Coverage under Federal Law (COBRA); and
- coverage would terminate because coverage had been continued for the maximum period. Your surviving spouse is 60 years of age or older on the date of your death.
- A request is made for continued coverage within 31 days after your death; and
- Payment is made for the coverage.

Such spouse must agree to pay up to 120% of the full cost to the Plan and premium payments must be continued

Your dependent's coverage will end when the first of the following occurs:

- The end of the 12 month period following your death;
- He or she no longer meets the plan's definition of "dependent";
- Dependent coverage is discontinued under the group contract;
- He or she becomes eligible for comparable benefits under this or any other group plan; or
- Any required contributions stop; and
- The date the surviving spouse becomes eligible for Medicare; or
- For your spouse, the date he or she remarries.

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

Continuing Coverage After You Terminate Employment

The following applies only if you have been covered for Health Expense Coverage for at least 6 months in a row.

If you terminate employment, you may continue any Health Expense Coverage except Dental Expense Coverage in force for you and your dependents after it would otherwise terminate but only if:

- Termination is not due to cause.
- You agree within 31 days of the date coverage would otherwise cease to make the contributions needed.
- The coverage is not replaced right away by other group coverage.
- The group contract is still in force as to your Eligible Class.

Coverage will cease on the first to occur of:

- The end of the 3 month period following the end of the group contract month in which coverage would otherwise cease.
- The date you are eligible for coverage under any group plan that provides like benefits or services.
- You fail to make the contributions needed.
- Health Expense Benefits discontinue as to employees of your former Employer.

Coverage for a dependent will cease earlier when the person:

- ceases to be a defined dependent; or

- becomes eligible for other coverage under the group contract.

Continuing Coverage For Your Former Spouse

If Health Expense Coverage for your former spouse would terminate:

- because of divorce; or
- because the spouse has continued coverage for the maximum period for which coverage may be continued in accordance with Continuation of Coverage Under Federal Law (COBRA);

and the former spouse was 60 years of age or older on the date of the divorce, the former spouse may elect to continue any such coverage in force for him or herself and any eligible dependent children then covered. The former spouse must agree to pay up to 120% of the full cost to the Plan. Premium payments must be continued.

Coverage will not be continued beyond the first to occur of:

- The date you are no longer covered under this Plan.
- The date the former spouse becomes covered for like coverage under any group plan.
- The date dependent coverage ceases under this Plan for your Eligible Class.
- The date the former spouse becomes eligible for Medicare.

A dependent child's coverage will cease earlier when the child:

- ceases to be a defined dependent; or
- becomes covered for like coverage under any group plan.

You may not terminate your spouse’s coverage under this Plan while you are legally separated and not yet divorced.

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious **illness** or **injury**, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. **Aetna** may require a written certification from the treating **physician** which states that the child is suffering from a serious **illness** or **injury** and that the resulting leave of absence (or change in full-time student status) is **medically necessary**.

Important Note
If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, *Handicapped Dependent Children*, for more information.

Handicapped Dependent Children

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

Extension of Benefits

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the **injury** or **illness** that caused the total disability. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage

Medical and Pediatric Dental Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a "qualifying event" that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer's notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled.

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

Important Note
For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

Coordination of Benefits - What Happens When There is More Than One Health Plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. "Plan" and "This plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable deductible, that is covered at least in part by any of the **Plan** covering the person. When a **Plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the **Plans** is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **allowable expense**. The following are examples of expenses and services that are ***not*** **allowable expenses**:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **Plans** provides coverage for a private room.
2. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an **allowable expense**.
4. The amount a benefit is reduced or not reimbursed by the **primary plan** because a covered person does not comply with the **Plan** provisions is not an **allowable expense**. Examples of these provisions are second surgical opinions, **precertification** of admissions, and preferred provider arrangements.
5. If all **plans** covering a person are high deductible **plans** and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible **plan's** deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one **Plan** that computes its benefit payments on the basis of reasonable or **recognized charges** and another **Plan** that provides its benefits or services on the basis of **negotiated charges**, the **primary plan**'s payment arrangements shall be the allowable expense for all the **Plans**. However, if the **secondary plan** has a negotiated fee or payment amount different from the **primary plan** and if the provider contract permits, that negotiated fee will be the **allowable expense** used by the **secondary plan** to determine benefits.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any **Plan** providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans**,** or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, Medical coverage will be coordinated with other Medical **plans**, and dental coverage will be coordinated with other dental **plans**.

This Plan is any part of the policy that provides benefits for health care expenses.

Primary Plan / **Secondary Plan.** The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the **custodial parent**;
      - The plan of the non**custodial parent**; and then
      - The plan of the spouse of the non**custodial parent**.

      For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Work

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **This Plan**, the amount normally reimbursed for covered benefits or expenses under **This Plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise

payable under **This Plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **This Plan** and another plan both agree that **This Plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plans** COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

Medicare, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It 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** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  - Refused it;
  - Dropped it; or
  - Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

Aetna will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

Type of Coverage

Coverage under this plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. This plan covers charges made for services and supplies only while the person is covered under this plan.

Physical Examinations

Aetna will have the right and opportunity to have a **physician** or **dentist** of its choice examine any person who is requesting certification or benefits for new and ongoing claims. Multiple exams, evaluations, and functional capacity exams may be required during your disability for an ongoing claim. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of this plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna**'s *Notice of Information Practices* by calling Member Services at the number on the back of the ID card.

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the *group* contract. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments

An assignment is the transfer of your rights under the group policy to a person you name.

All coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, **Aetna** will not accept an assignment to an **out-of-network provider**, including but not limited to, an assignment of:

The benefits due under this group insurance policy;
The right to receive payments due under this group insurance policy; or
Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.

Misstatements

If any fact as to the employer or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the employer or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna's failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the employer or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the employer shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Rescission of Coverage

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

You have the right to an internal **Appeal** with **Aetna** and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

Right of Recovery

As used herein, the term "**Third Party**", means any party that is, or may be, or is claimed to be responsible for **illness** or **injuries** to you. Such **illness** or **injuries** are referred to as "**Third Party Injuries**." "**Third Party**" includes any party responsible for payment of expenses associated with the care of treatment of **Third Party Injuries.**

If the covered person has a claim for damages or a right to recover damages from a **Third Party** or parties for an illness or injury for which benefits are payable under this plan, Aetna may have a right for recovery. Aetna's right of recovery shall be limited to the recovery of any benefits paid for identical **covered expenses** under this Plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Aetna's right of recovery may include compromise settlements. The covered person's attorney must inform Aetna of any legal action or settlement agreement at least ten days prior to settlement or trial. Aetna will then notify the covered person of the amount it seeks to recover for covered benefits paid. Aetna's recovery may be reduced by the pro-rata share of the covered person's attorney's fees and expenses of litigation.

Workers' Compensation

If benefits are paid by **Aetna** and **Aetna** determines you received Workers' Compensation benefits for the same incident, **Aetna** has the right to recover as described under the *Right of Recovery* provision. **Aetna** will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily **injury** or **illness** was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna** as described above.

If benefits are paid under this policy and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna** has a right to recover from you or your covered dependent an amount equal to the amount **Aetna** paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 15 days of receipt by **Aetna** of the due written proof. If the claim has not been paid, or has not been denied for valid and proper reasons, by the end of the 15 day period, Aetna will pay the insured or claimant interest on accrued benefits at the rate of 18 percent per annum on the amount of the claim, until the claim is settled.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When **a network provider** (**network services or supplies**) provides care to you or a covered dependent, the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Financial Sanctions Exclusions

If coverage provided under this policy 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 it is permitted under a written license from the Office of Foreign Asset Control (OFAC).
For more information visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Prior Coverage - Transferred Business

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

health coverage under this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period as provided under the section, *Continuing Coverage for Dependent Students on Medical Leave of Absence.*

Wellness and Other Incentives

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as an **Aetna** member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program. Incentives include but are not limited to: modifications to copayment, deductible, or coinsurance amounts; premium discounts or rebates; contributions to a health savings account; fitness center membership reimbursement; merchandise; coupons; gift cards; debit cards; or any combination of thereof. The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.

Appeals Procedure

Definitions

Adverse Benefit Determination (Decision): This is:

(a) A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit.
(b) A denial of eligibility for coverage.
(c) Rescission (retroactive termination) of coverage.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- 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**.
- A decision that the service, supply or **prescription drug** is not **medically necessary**.

An **adverse benefit determination** also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Appeal: A written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any written expression of dissatisfaction about quality of care or the operation of the Plan.

Concurrent Care Claim Extension: A request to extend a course of treatment that was previously approved.

Concurrent Care Claim Reduction or Termination: A decision to reduce or terminate a course of treatment that was previously approved.

External Review: A review of an **adverse benefit determination** or a **final adverse benefit determination** by an Independent Review Organization/External Review Organization (ERO) assigned by the Georgia Insurance

Commissioner made up of **physicians** or other appropriate health care **providers**. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An **adverse benefit determination** that has been upheld by **Aetna** at the exhaustion of the appeals process.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a "Pre-Service Claim."

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the **final adverse benefit determination** is required to be provided so that you may respond prior to that date.

Prior to issuing a **final adverse benefit determination** based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of **final adverse determination** is required.

Claim Determinations – Group Health Coverage

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If **Aetna** makes an **adverse benefit determination**, written notice will be provided to you, or in the case of a concurrent care claim, to your **provider**.

Urgent Care Claims
Aetna will notify you of an **urgent care claim** decision as soon as possible, but not later than72 hours after the claim is made.

If more information is needed to make an **urgent care claim** decision, **Aetna** will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide **Aetna** with the additional information. **Aetna** will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the **physician** to provide **Aetna** with the information.

Pre-Service Claims
Aetna will notify you of a **pre-service claim** decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Post-Service Claims
Aetna will notify you of a **post-service claim** decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of no longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to

make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

Concurrent Care Claim Extension
Following a request for a **concurrent care claim extension**, **Aetna** will notify you of a claim decision for **urgent care** as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a **concurrent care claim extension**.

Concurrent Care Claim Reduction or Termination
Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an **appeal**.

If you file an **appeal**, coverage under the plan will continue for the previously approved course of treatment until a final **appeal** decision is rendered. During this continuation period, you are responsible for any **copayments**; **coinsurance**; and **deductibles**; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under **appeal**. If **Aetna's** initial claim decision is upheld in the final **appeal** decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about an **network provider** you must write Member Services. The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. **Aetna** will review the information and provide you with a written response within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations

You may submit an **appeal** if **Aetna** gives notice of an **adverse benefit determination**. As to medical and prescription drug claims only, a final **adverse benefit determination** notice will include statements and information on how to request an External Review (including an expedited External Review). This Plan provides for one level or two levels of **appeal** depending upon the type of coverage provided under the Plan. A **final adverse benefit determination** notice may also provide an option to request an **External Review** *(if available*)**.**

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an **adverse benefit determination** to request your Level One **Appeal**. Your **appeal** must be submitted in writing and must include:

- Your name.
- Your employer's name.
- Your reasons for making the **appeal**.
- Any other information you would like to have considered.

Send your written **appeal** to Member Services at the address shown on your ID Card.

You may also choose to have another person (an authorized representative) make the **appeal** on your behalf. You must provide written consent to **Aetna**.

You may be allowed to provide evidence or testimony during the **appeal** process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Level One Appeal – Group Health Claims

For Utilization Review

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

For Other Than Utilization Review

A review of a Level One **Appeal** of an **adverse benefit determination** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 24 hours of receipt of the request for an **appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an **appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an **appeal**.

Level Two Appeal - Group Health Claims *(For Other Than Utilization Review)*

If **Aetna** upholds an **adverse benefit determination** at the first level of **appeal**, and the reason for the decision was based on **medical necessity** or **experimental or investigational** reasons, you or your authorized representative have the right to file a Level Two **Appeal**. The **appeal** must be submitted within 60 calendar days following the receipt of a decision of a Level One **Appeal**.

Review of a Level Two **Appeal** of an **adverse benefit determination** of an **urgent care claim, a Pre-Service Claim, or a Post-Service Claim** shall be provided by **Aetna** personnel. They shall not have been involved in making the **adverse benefit determination**.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 24 hours of receipt of the request for a Level Two **Appeal**.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for a Level Two **Appeal**.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for a Level Two **Appeal**.

Exhaustion of Process

Aetna encourages you to exhaust the applicable Level One and Level Two processes of the Appeal Procedure before you:

- Contact the Georgia Department of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Georgia Department of Insurance; or
- Establish any:
  - litigation; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by **Aetna** or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and **External Review** processes—these include **Urgent Care Claims** and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:

If **Aetna** does not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the **appeal** requirements and may proceed with **External Review** or any of the actions mentioned above. There are limits, though, on what sends a claim or **appeal** straight to an **External Review**. Your claim or internal **appeal** *will not* go straight to **External Review** if:

- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond **Aetna's** control; and
- it was part of an ongoing, good faith exchange between you and **Aetna**.

External Review

You may receive an **adverse benefit determination** or **final adverse benefit determination** because **Aetna** determines that:

- The claim involves medical judgment;
- The care is not **necessary** or appropriate; or
- A service, supply or treatment is **experimental or investigational** in nature.

In these situations, you may request an **External Review** if you or your **provider** disagrees with **Aetna's** decision.

To request an **External Review**, any of the following requirements must be met:

- You have received an **adverse benefit determination** notice by **Aetna,** and **Aetna** did not adhere to all claim determination and **appeal** requirements of the Federal Department of Health and Human Services.
- You have received a **final adverse benefit determination** notice of the denial of the claim by **Aetna**.
- Your claim was denied because **Aetna** determined that the care was not **necessary** or appropriate or was **experimental or investigational**.
- You qualify for a faster review as explained below.

The notice of **adverse benefit determination** or **final adverse benefit determination** that you receive from **Aetna** will describe the process to follow if you wish to pursue an **External Review**, and will include a copy of the *Request for External Review Form*.

You must submit the Request for External Review Form:

- To **Aetna**
- Within 123 calendar days of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

They will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers 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 ERO usually within 45 calendar days of **Aetna's** receipt of your request form and all the necessary information.

A faster 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:

- Seriously jeopardize your life or health; or
- Jeopardize your ability to regain maximum function; or
- If the **adverse benefit determination** relates to **experimental or investigational** treatment, if the **physician** certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.

You may also receive a faster review if the **final adverse benefit determination** relates to an admission; availability of care; continued **stay;** or health service for which you received **emergency care**, but have not been discharged from a facility.

Faster reviews are decided within 72 hours after **Aetna** receives the request.

Aetna will abide by the decision of the ERO, 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 ERO to **Aetna**. **Aetna** is responsible for the cost of sending this information to the ERO and for the cost of the external review except for dental, vision and hearing claims.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

A

Accident

This means a sudden; unexpected; and unforeseen; identifiable **occurrence** or event producing, at the time, objective symptoms of a bodily **injury**. The **accident** must occur while the person is covered under this Policy. The **occurrence** or event must be definite as to time and place. It must not be due to, or contributed by, an **illness** or disease of any kind.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Biosimilar Prescription Drugs

A biological **prescription drug** that is highly similar to a U.S. Food and Drug Administration (FDA) licensed reference biological **prescription drug** notwithstanding minor differences for which there are no clinically meaningful differences between the highly similar biological **prescription drug** and the reference biological **prescription drug** in terms of the safety, purity, and potency of the drug. As defined in accordance with U.S. Food and Drug Administration (FDA) regulations.

Birthing Center

A freestanding facility that meets ***all*** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.

- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Body Mass Index
This is 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 Prescription Drug
A U.S. Food and Drug Administration (FDA) approved **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medi-Span or similar publication designated by **Aetna**.

C

Coinsurance
Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as "plan **coinsurance**" and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

Copayment (Copay)
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;

- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

Dental Provider

This is:

- Any **dentist**;
- Group;
- Organization;
- Dental facility; or
- Other institution or person;

that is legally qualified to furnish dental services or supplies.

Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all **network providers** serving the class of employees to which you belong. The employer will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Important Reminder: Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

E-visit
A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Emergency Admission
An admission to a **hospital** or **residential treatment facility** by a **physician** who admits you right after the sudden and, at that time, unexpected onset of an **emergency medical condition**, which requires confinement right away as a full-time inpatient.

Emergency Care
This means the treatment given in a **hospital**'s emergency room to evaluate, stabilize and treat an **emergency medical condition**.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the U.S. Food and Drug Administration (FDA) 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 investigational**, or for research purposes; or
- It is a type of drug, device, procedure, or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

  that states that it is **experimental or investigational**, or for research purposes.

G

Generic Prescription Drug

A prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration (FDA) as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medi-span or similar publication designated by Aetna.

H

Habilitation

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Important Reminder:
Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and

  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

Hospitalization
A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

Injury
An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)
A **hospital** or other facility that has contracted with **Aetna** to give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

J

Jaw Joint Disorder
This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L

Late Enrollee
This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the Booklet-Certificate.

Lifetime Maximum
This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

L.P.N.
A licensed practical or vocational nurse.

M

Mail Order Pharmacy
An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit
The **maximum-out-of-pocket limit** is the maximum amount you are responsible to pay for **covered expenses** during the **calendar year**. Your **deductibles**, **coinsurance**, **copayments** and other eligible out-of-pocket expenses apply to the **maximum out-of-pocket limit**.

Medically Necessary or Medical Necessity
These are health care or dental services that we determine a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must, as we determine, be:

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

"Generally accepted standards of medical or dental practice" means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature. They must be generally recognized by the relevant medical or dental community;
- Standards set forth in policy issues involving clinical judgment

Mental Disorder
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 **psychiatrist**, a psychologist or a psychiatric social worker.

Any one of the following conditions is a **mental disorder** under this plan:

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

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity
This means 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 comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N
Negotiated Charge
As to Health Expense Coverage,(other than Prescription Drug Expense Coverage):
The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna,** an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

Network Pharmacy
A retail **pharmacy**, **mail order pharmacy** or **specialty network pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, to furnish services and supplies for this plan.

Network Provider
A health care provider, **pharmacy** or **dental provider** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna**'s consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a **network provider**; or
- Furnished or arranged by your **PCP**.

Non-Occupational Illness
A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

Non-Occupational Injury
A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

Non-Preferred Drug (Non-Formulary)
A **prescription drug** or device that is not listed in the **preferred drug guide (formulary)**. This includes **prescription drugs** and devices that might be initially excluded from coverage but may be approved my medical exception.

Non-Specialist
A **physician** who is not a **specialist**.

Non-Urgent Admission
An inpatient admission that is not an **emergency admission** or an **urgent admission**.

Occupational Injury or Occupational Illness
An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence
This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- Furnished by an **out-of network provider**; or
- Not furnished or arranged by your **PCP**.

Out-of-Network Pharmacy
A **pharmacy** that has not contracted with **Aetna,** an affiliate, or a third party vendor and does not participate in the **pharmacy** network.

Out-of-Network Provider
A health care provider, **pharmacy** or **dental provider** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

P

Partial Hospitalization Treatment
A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **substance abuse** or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital**; **psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in line with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatrist** who weekly reviews and evaluates its effect.

Pharmacy
An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty network pharmacy**.

Physician
A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by **substance abuse** or a **mental disorder**; and
- A **physician** is not you or related to you.

Precertification, Precertify, Precertified
A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that you were not eligible for benefits at that time.

Preferred Drug (Formulary)
A **prescription drug** or device that is listed on the **preferred drug guide (formulary)**.

Preferred Drug Guide (Formulary)
A listing of **prescription drugs** and devices established by **Aetna** or an affiliate. It does not include all **prescription drugs** and devices. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide (formulary)** will be available upon your request or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

Preferred Drug Guide Exclusions List
A list of **prescription drugs** and devices in the **preferred drug guide (formulary)** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna** or an affiliate.

Preferred Network Pharmacy
A network **retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** to you.

Prescriber
Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription

*As to **prescription drugs**:*
A written order for the dispensing of a **prescription drug** by a **prescriber**. If it is a verbal order, it must promptly be put in writing by the **pharmacy**.

As to vision care:
A written order for the dispensing of **prescription** lenses or **prescription** contact lenses by an ophthalmologist or optometrist.

Prescription Drug
A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription**. This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional.

Primary Care Physician (PCP)
This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician and, if available within the network, an obstetrician or gynecologist;
- Maintains continuity of patient care; and
- Is shown on **Aetna**'s records as the person's **PCP**.

Provider
This is any recognized health care professional, pharmacy or facility providing services within the scope of their license.

Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of **substance abuse** or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatrist** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatrists** involved in care and treatment.
- Has a **psychiatrist** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatrist**.
- Makes charges.
- Meets licensing standards.

Psychiatrist
This is a **physician** who:

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

R

Recognized Charge
The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge.** The **recognized charge** may be less than the **provider's** full charge.
Your plan's **recognized charge** applies to all out-of-network **covered benefits** except out-of-network **emergency services**. It applies even to charges from an **out-of-network provider** in a **Hospital** that is a **network provider**. It also applies when your **PCP** or other **network provider** refers you to an **out-of-network provider.**

Except for **Aetna** Facility Fee Schedule, the **recognized charge** is determined based on the Geographic area where you receive the service or supply.

Except as otherwise specified below the **recognized charge** for each service or supply is the lesser of what the **provider** bills and**:**

- For professional services and other services or supplies not mentioned below:
  - 90% of the Medicare Allowable Rate

- For services of **hospitals** and other facilities:
  - 90% of the Medicare Allowable Rate

- For **Prescription Drugs**:
  - 50% of the Average Wholesale Price, (AWP).

- For dental expenses:
  - 80% of the Prevailing Charge Rate

If your ID card displays the National Advantage Program (NAP) logo, the **Recognized Charge** is the lesser of the rate we have negotiated with your NAP **provider** or the **Recognized Charge** that would apply if your plan did not include NAP. Your out-of-network cost sharing applies when you get care from NAP **providers**. except for **emergency services.**

A NAP **provider** is a **provider** with whom we have a contract through any third party that is not an affiliate of **Aetna** or through the **Coventry National** or **First Health Networks.**However, a NAP **provider** listed in the NAP directory is not a **network provider**.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge.** These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
- The educational level, licensure or length of training of the **provider**

Aetna reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Aetna Facility Fee Schedule, Average Wholesale Price (AWP), Geographic Area, Prevailing Charge Rates, Medicare Allowable Rates, are defined as follows:

Aetna Facility Fee Schedule
The schedule of rates we developed using our data or experience for **out-of-network** facility services and supplies. This schedule is the same for all facilities within a Geographic area. We adjust the schedule from time to time at our discretion.

Average Wholesale Price (AWP)
Is the current average wholesale price of a **prescription drug** listed in the Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

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

Medicare Allowable Rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

- Use our reasonable judgment to set a rate.
- Use the same method CMS uses to set Medicare rates.
- Look at what other providers charge.
- Look at how much work it takes to perform a service.
- Look at other things as needed to decide what rate is reasonable for a particular service or supply.

Prevailing Charge Rates: The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, **Aetna** has the right to substitute an alternative database that **Aetna** believes is comparable.

Additional information:

Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network.**Aetna**'s secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

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

In addition to the above requirements, for Mental Health Residential Treatment Program:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week.
- The patient is treated by a **psychiatrist** at least once per week.
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

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

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

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

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R.N.** is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

Retail Pharmacy

A community **pharmacy** which has contracted with **Aetna**, an affiliate, or a third party vendor, to provide covered outpatient **prescription drugs** to you.

R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorder**s.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by**:**
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist
A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care
Health care services or supplies that require the services of a **specialist**.

Specialty Care Prescription Drugs
Injectable, infusion and oral **prescription drugs that are** prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.

You can access the list of these **specialty care prescription drugs** by calling the toll-free Member Services number on your member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com.

Specialty Network Pharmacy
A network of **pharmacies** designated to fill **prescriptions** for **self-injectable drugs** and **specialty care prescription drugs**.

Stay
A full-time inpatient confinement for which a **room and board** charge is made.

Step Therapy
A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.**Aetna**.com/formulary.

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

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- Is licensed as an ambulatory surgical facility.
- Is set up, equipped and run to provide general surgery.
- Charges for its services and supplies.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.

- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Telemedicine

A telephone or internet-based consult with a **provider** that has contracted with **Aetna** to offer these services.

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

Tier 1A

A group of medications determined by us that may be available at a reduced **copayment/coinsurance** and are noted in the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.aetna.com/formulary.

Tier 1

A group of medications determined by us that may be available at a reduced **copayment/coinsurance** and are noted on the **Preferred Drug Guide (Formulary)** on the **Aetna** website at www.aetna.com/formulary.

U

Urgent Admission

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

Urgent Condition

This means a sudden **illness**; **injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a **hospital**; and
- Requires immediate outpatient medical care that cannot be postponed until your **physician** becomes reasonably available.

W

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. Neither of the following should be considered a **Walk-in Clinic**:

- An emergency room; nor
- The outpatient department of a **hospital.**

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Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.

Additional Information Provided by

Your Employer

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Note: This sub-section applies to the Plan if your Employer employs 20 or more employees in accordance with a formula mandated by federal law. Check with your Employer to determine if COBRA continuation applies to the Plan.

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) 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 provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/home/regsguidance.asp, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

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 insurance 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.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

Note: This sub-section applies to the Plan if your Employer employs 50 or more employees as determined by a formula defined by federal law. Check with your Employer to determine if FMLA applies to the Plan.

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Open Access Managed Choice Medical Insurance plan

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. If the **Policyholder** is a church group or a government group this may not apply. Please contact the **Policyholder** for additional information.

Underwritten by Aetna Life Insurance Company in the state of Georgia

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Schedule of Benefits

This Schedule of Benefits lists the **Deductibles** and **Copayments** or **Coinsurance**, if any that apply to the services you receive under this plan. You should review this schedule to become familiar with **Deductibles** and **Copayments** or **Coinsurance** and any limits that apply to the services.

How to read your Schedule of Benefits

- You are responsible to pay any **Deductibles** and **Copayments** or **Coinsurance**.
- You are responsible for full payment of any health care services you receive that are not a covered benefit.
- This plan has maximums for specific covered benefits. For example, these could be visit, day or dollar maximums. They may be combined maximums or separate maximums between **Network Providers** and **Out-of-Network Providers** unless we state otherwise.

Important Note:
All covered benefits are subject to the **Deductible** and **Copayment** or **Coinsurance** unless otherwise noted in the Schedule of Benefits below.

For answers to any questions, contact Member Services by logging onto the Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on the member ID card.

The coverage described in this Schedule of Benefits will be provided under **Aetna Life Insurance Company's** Group Policy**.** This Schedule of Benefits replaces any Schedule of Benefits previously in effect under the Group Policy. Keep this Schedule of Benefits with your Booklet-Certificate**.**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Plan Features	Cost Share/Deductible/Limits	
	In-Network Coverage*	**Out-of-Network Coverage***
Deductible		
You have to meet your **Deductible** before this plan pays for benefits.		
Individual	$1,000 per Calendar Year	$2,000 per Calendar Year
Family	$2,000 per Calendar Year	$4,000 per Calendar Year
Deductible waiver		
The **Deductible** is waived for all of the following Eligible Health Services**:** • In-Network Preventive Care • In-Network and Out-of-Network Routine Physical Exams for Covered Persons to age 22 (includes coverage for Immunizations) • In-Network Family Planning Services - Female Contraceptives		

Maximum Out-of-Pocket Limit		
Maximum Out-of-Pocket Limit per Calendar Year		
Individual	$4,000 per Calendar Year	$12,000 per Calendar Year
Family	$8,000 per Calendar Year	$24,000 per Calendar Year
Precertification Covered Benefit Reduction		
This only applies to out-of-network coverage: The **Booklet-Certificate** contains a complete description of the **Precertification** program. You will find details on **Precertification** requirements in the *Medical necessity and Precertification Requirements* section. Failure to **Precertify** Eligible Health Services when required will result in the following benefits reduction: • A $400 benefit reduction will be applied separately to each type of Eligible Health Service The additional percentage or dollar amount of the **Recognized Charge** which you may pay as a penalty for failure to obtain **Precertification** is not a **covered benefit**, and will not be applied to the **Deductible** amount or the **Maximum Out-of-Pocket Limit**, if any.		

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum Out-of-Pocket Limits**
- Limits

that are listed in this Schedule of Benefits.

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Deductible Provisions

Eligible Health Services applied to the out-of-network **Deductibles** will not be applied to satisfy the in-network **Deductibles**. Eligible Health Services applied to the in-network **Deductibles** will not be applied to satisfy the out-of-network **Deductibles**.

The **Deductible** may not apply to certain Eligible Health Services. You must pay any applicable **Copayments** or **Coinsurance** for Eligible Health Services to which the **Deductible** does not apply.

Individual

This is the amount you owe for Eligible Health Services each Calendar Year before the plan begins to pay for Eligible Health Services. This Calendar Year **Deductible** applies separately to you and each Covered Dependents. After the amount you pay for Eligible Health Services reaches the Calendar Year **Deductible**, this plan will begin to pay for Eligible Health Services for the rest of the Calendar Year.

Family

This is the amount you owe for Eligible Health Services each Calendar Year before the plan begins to pay for Eligible Health Services. After the amount you pay for Eligible Health Services reaches this family Calendar Year **Deductible**, this plan will begin to pay for Eligible Health Services that you incur for the rest of the Calendar Year.

Deductible carryover

Under this feature, any amounts that you paid for **eligible health services** in the last three months of a calendar year that apply toward that year's in-network or out-of-network calendar year **deductibles** will also count toward the following year's in-network or out-of-network calendar year **deductibles**.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that you must pay at the time Eligible Health Services are received from a Participating **Provider**. As it applies to in-network coverage, if **Aetna** compensates Participating **Providers** on the basis of the reasonable amount, your cost share is based on this amount.

Per admission **Copayment**

A per admission **Copayment** is an amount required to be paid when you or a covered dependent have a stay as an inpatient in an inpatient facility.

The per admission **Copayment** or **Deductible** amount is equal to a facility's semi-private room rate for one day. However, for the inpatient stay of a well newborn baby (starting at birth), the per admission **Copayment** or **Deductible** amount will not exceed the **Hospital**'s actual room and board charge on the first day of the inpatient stay.

Coinsurance

The specific percentage you have to pay for a health care service listed in the Schedule of Benefits.

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Maximum Out-of-Pocket Limits Provisions

Eligible Health Services that are subject to the **Maximum Out-of-Pocket Limit** include **Prescription Drug** Eligible Health Services provided under the medical plan and the **Outpatient Prescription Drug** plan.

Eligible Health Services applied to the Out-of-Network **Maximum Out-of-Pocket Limit** will not be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and Eligible Health Services applied to the in-network **Maximum Out-of-Pocket Limit** will not be applied to satisfy the Out-of-Network **Maximum Out-of-Pocket Limit**.

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **Copayments, Coinsurance** and **Deductibles** for Eligible Health Services during the Calendar Year. This plan has an individual and family **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit,** each member must meet their **Maximum Out-of-Pocket Limit** separately.

Individual

Once the amount of the **Copayments, Coinsurance** and **Deductibles** you or your covered dependents have paid for Eligible Health Services during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this plan will pay 100% of the covered benefits that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **Copayments** or **Coinsurance** and **Deductibles** you or your covered dependents have paid for Eligible Health Services during the Calendar Year meets this family **Maximum Out-of-Pocket Limit**, this plan will pay 100% of the covered benefits that apply toward the limit for the remainder of the Calendar Year for all covered family members.

The **Maximum Out-of-Pocket Limit** may not apply to certain Eligible Health Services. If the **Maximum Out-of-Pocket Limit** does not apply to a covered benefits, your **Copayment** or **Coinsurance** for that covered benefit will not count toward satisfying the **Maximum Out-of-Pocket Limit** amount.

Certain costs that you incur do not apply toward the **Maximum Out-of-Pocket Limit**. These include:

- As it applies to Out-of-Network coverage: Charges, expenses or costs in excess of the **Recognized Charge**
- All costs for non-covered services
- Certain other Eligible Health Services in the Schedule of Benefits

Limit Provisions

Eligible Health Services applied to the Out-of-Network limit will be applied to satisfy the network limit and Eligible Health Services applied to the network limit will be applied to satisfy the Out-of-Network limit.

Calculations; Determination of Recognized Charge; determination of Benefits Provisions

Your responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the Booklet-Certificate.

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
1. Preventive Care and wellness • **Routine Physical Exams-** Performed at a **Physician, PCP** office • **Preventive Care Immunizations-** Performed in a facility or at a **Physician** office • **Well Woman Preventive Visits-** routine gynecological exams (including pap smears)- Performed at a **Physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office • **Screening and Counseling Services -** Includes obesity and/or healthy diet counseling, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling, genetic risk counseling for breast and ovarian cancer - Office visits • **Routine Cancer Screenings** - (applies whether performed at a **Physician, PCP**, **Specialist** office or facility) • **Prenatal Care -** (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN) • **Comprehensive Lactation Support and Counseling Services -** Facility or office visits • **Family Planning Services – Female Contraceptives**		
Preventive Care and wellness described above	0% per visit	30% **coinsurance** after **deductible**
Well Baby/Child Exams (including immunizations)	0% per visit	30%, no **deductible** applies
Preventive Care Limitations		
Routine Physical Exams		
Limitations Covered Persons to age 22	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact the **Physician.**	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact the **Physician.**
Covered Persons age 22 and older	Coverage is limited to 1 visit per **calendar year.**	Coverage is limited to 1 visit per **calendar year.**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Preventive Care Immunizations		
Limitations	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact the **Physician.**	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact the **Physician.**
Well Woman Preventive Visits **Routine Gynecological Exams (Including Pap Smears)**		
Limitations	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Screening and Counseling Services: limitations are per Calendar Year unless stated		
Obesity and/or Healthy Diet	Coverage is limited to: age 0-22, unlimited visits; age 22+, 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling.	Coverage is limited to: age 0-22, unlimited visits; age 22+, 26 visits every 12 months, of which up to 10 visits may be used for healthy diet counseling.
Misuse of Alcohol and/or Drugs	Coverage is limited to 5 visits every 12 months	Coverage is limited to 5 visits every 12 months
Use of Tobacco Products	Coverage is limited to 8 visits every 12 months.	Coverage is limited to 8 visits every 12 months.
Sexually Transmitted Infection	Coverage is limited to 2 visits every 12 months.	Coverage is limited to 2 visits every 12 months.
Genetic Risk Counseling for Breast and Ovarian Cancer	Not subject to any age or frequency limitations	Not subject to any age or frequency limitations

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Routine cancer screenings		
Limitations:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and The comprehensive guidelines supported by the Health Resources and Services Administration. **Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the** *Outpatient diagnostic testing* section**.**	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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; and The comprehensive guidelines supported by the Health Resources and Services Administration. **Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the** *Outpatient diagnostic testing* section**.**
Comprehensive Lactation Support and Counseling Services		
Lactation counseling services visit limits per Calendar Year either in a group or individual setting ***Any visits that exceed the lactation counseling services limit are covered under** *physician services* **office visits.**	Coverage is limited to 6 visits*	Coverage is limited to 6 visits*
Breast Feeding Durable Medical Equipment		
Important Note: You should review the *Maternity and Related Newborn Care* sections. They will give you more information on coverage levels for maternity care under this plan. See the *Breast Feeding Durable Medical Equipment* section of the Certificate for limitations on breast pump and supplies.		
Family Planning Services – Female Contraceptives		
Contraceptive counseling services visit limits per Calendar Year either in a group or individual setting	Coverage is limited to 2 visits	Coverage is limited to 2 visits

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

2. Additional Covered Medical Expenses		
Family Planning Services - Other		
Inpatient Services		
Voluntary sterilization for males	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Voluntary termination of pregnancy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient Services		
Voluntary sterilization for males	Covered according to the type of benefit and the place where the service is received	40% **coinsurance** after **deductible**
Voluntary termination of pregnancy	Covered according to the type of benefit and the place where the service is received	40% **coinsurance** after **deductible**
Vision Care		
Pediatric Vision Care **Coverage is limited to covered persons through the end of the month in which the person turns 19**		
Routine Vision Exams (including refraction)		
Performed by an ophthalmologist or optometrist	0% **coinsurance** no **deductible** applies	30% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 1 exam every 12 months.	Coverage is limited to 1 exam every 12 months.
Vision Care Services and Supplies		
Office visit for fitting of contact lenses	Not covered	Not covered
Eyeglass frames, **Prescription** lenses or **Prescription** contact lenses.	0% **coinsurance** no **deductible** applies	30% **coinsurance** after **deductible**
Number of eyeglass frames per Calendar Year	One set of eyeglass frames	
Number of **Prescription** lenses per Calendar Year	One pair of **Prescription** lenses	
Number of **Prescription** contact lenses per Calendar Year (includes non-conventional **Prescription** contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
3. Physician Services		
Physician Visits		
Office hours visits (non-surgical) non preventive care	$20 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Immunizations When Not Part of the Physical Exam		
Immunizations when not part of the physical exam	0% **coinsurance** no **deductible** applies	30% **coinsurance** no **deductible** applies
Physician Surgical Services		
Performed at a **Physician** or **Specialist** office	Covered same as **PCP/Specialist**	40% **coinsurance** after **deductible**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
4. Alternatives to Physician Office Visits		
Walk-in Clinic Visits		
Walk-In Clinic non-emergency visit (includes coverage for immunizations.)	$20 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Limitations	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact the **Physician.**	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact the **Physician.**
Individual Screening and Counseling Services* Includes Obesity and/or Healthy Diet Counseling, Use of Tobacco Products, Stress Management Services		
Individual Screening and Counseling Services	0% **coinsurance** no **deductible** applies	30% **coinsurance** after **deductible**
Refer to the *Preventive Care* section earlier in this Schedule of Benefits for maximums that may apply to these types of services.		
***Important Note:** Not all preventive care and stress management services are available at all **Walk-in Clinics.** The types of services offered will vary by the **Provider** and location of the clinic. These services may also be obtained from a network **Physician**.		
E-Visits Consultations		
***E-visit online consultation by a* Physician, PCP**	Covered according to the type of benefit and the place where the service is received	40% **coinsurance** after **deductible**
Injectable Medications		
Performed at a Physician, PCP or **Specialist** office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Specialist Office Visits		
Office hours visit (non-surgical)	$50 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
E-Visits Consultations		
E-visit online consultation by a Specialist	Covered according to the type of benefit and the place where the service is received	40% **coinsurance** after **deductible**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
5. Hospital Expense		
Hospital		
Inpatient **Hospital**	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Coverage for Emergency Services		
A separate **hospital** emergency room or urgent care **Deductible** or **Copayment** or **Coinsurance** will apply for each visit to an emergency room or an **Urgent Care Facility**.		
Hospital emergency room	$300 **copay** no **deductible** applies	Paid the same as the network coverage
Non-emergency care in a **Hospital** emergency room	Not covered	Not covered
Important Note: As non-designated and **out-of-network Providers** do not have a contract with **Aetna** the **Provider** may not accept payment of your cost share (**Deductible, Copayment** and **Coinsurance**), as payment in full. **You** may receive a bill for the difference between the amount billed by the **Provider** and the amount paid by this plan. If the **Provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of the ID card, and **Aetna** will resolve any payment dispute with the **Provider** over that amount. Make sure that your ID number is on the bill. If you are admitted to a **Hospital** as an inpatient right after a visit to an emergency room, the emergency room **Deductible** or **Copayment** will be waived and the inpatient **Deductible** or **Copayment** will apply.		
Coverage for Urgent Conditions		
Urgent medical care at a non-**Hospital** free standing facility	$75 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Non-urgent use of **Urgent Care Facility** at a non-**Hospital** free standing facility	Not covered	Not covered

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Pregnancy Expenses		
Maternity and Related Newborn Care		
Inpatient and other maternity and related newborn care services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Birthing Center		
Inpatient birthing center services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Delivery Services and Postpartum Care Services		
Performed in a facility or at a **Physician** office	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Other prenatal care services	0% **coinsurance** no **deductible** applies	30% **coinsurance** after **deductible**
Pregnancy Complications		
Inpatient	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Other pregnancy complication services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**

Eligible Health Services	**In-Network Coverage***	**Out- of- Network Coverage***
6. Alternatives to Hospital Stays		
Outpatient Surgery and Physician Surgical Services		
Performed in **Hospital** outpatient department	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Performed in facility other than **Hospital** outpatient department	10% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Physician Services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Home Health Care		
Outpatient	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 60 visits per **calendar year.**	Coverage is limited to 60 visits per **calendar year.**
Skilled Nursing Facility		
Inpatient facility	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Day limit per Calendar Year	Coverage is limited to 50 days per **calendar year.**	Coverage is limited to 50 days per **calendar year.**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Hospice Care		
Inpatient facility and other **Hospice** benefits during a stay	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Outpatient Hospice Expenses		
Outpatient	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
7. Other Covered Healthcare Expenses		
Acupuncture		
Acupuncture (Anesthesia only)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Ambulance service		
Ground **Ambulance**	20% **coinsurance** after **deductible**	Covered same as in-network
Air or Water **Ambulance**	20% **coinsurance** after **deductible**	Covered same as in-network
Diagnostic and Preoperative Testing		
Diagnostic Complex Imaging Expenses		
Complex imaging services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Outpatient Diagnostic Lab Work		
Lab work	$0 **copay** no **deductible** applies	30% **coinsurance** after **deductible**
Outpatient Diagnostic Radiological Services		
X-ray	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Durable Medical and Surgical Equipment (DME)		
DME	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Orthotic Devices		
Orthotic devices	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Prosthetic Devices		
Prosthetic devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Short-Term Rehabilitation Therapy Services		
Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits		
Cognitive therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physical therapy and Occupational therapy	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 20 visits per **calendar year** PT/OT combined, rehabilitation & habilitation combined.	Coverage is limited to 20 visits per **calendar year** PT/OT combined, rehabilitation & habilitation combined.
Speech therapy	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 20 visits per **calendar year,** rehabilitation & habilitation combined.	Coverage is limited to 20 visits per **calendar year,** rehabilitation & habilitation combined.
Spinal manipulation		
Spinal manipulation	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 20 visits per **calendar year.**	Coverage is limited to 20 visits per **calendar year.**
Habilitation Therapy Treatment		
Therapies other than physical, occupational, and speech	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Visit limit per Calendar Year	Coverage is limited to 20 visits per **calendar year** PT/OT combined and 20 visits per **calendar year** ST, rehabilitation & habilitation combined.	Coverage is limited to 20 visits per **calendar year** PT/OT combined and 20 visits per **calendar year** ST, rehabilitation & habilitation combined.

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-network Coverage*
8. Specialized Care		
Reconstructive Breast Surgery		
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Reconstructive and Cosmetic Surgery and Supplies		
Reconstructive surgery and supplies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical Trial Therapies (Experimental or Investigational Treatment)		
Clinical trial therapies (including routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient Therapies		
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy		
Performed in a **Physician** office or in a person's home	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Performed in outpatient facility	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Diabetes		
Diabetic equipment,	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Diabetic supplies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Diabetic education	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Treatment of Basic Infertility		
Basic **infertility**	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism Spectrum Disorder		

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Autism Spectrum Disorder	20% **coinsurance**after **deductible**	40% **coinsurance** after **deductible**
Applied Behavioral Analysis	$50 **copay**	40% **coinsurance** after **deductible**
Jaw Joint Disorder		
Jaw Joint Disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Telemedicine		
Telemedicine	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
In-Hospital Dental Procedure		
In Hospital Dental Procedure Benefit **(see Booklet-Certificate for benefit details)**	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other services for which cost sharing is not shown above		
All Other Services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible Health Services	**In-Network Coverage*** **Network (IOE Facility)**	**Out-of-Network Coverage*** **Network (Non-IOE Facility)**
Transplant Services Facility and Non-Facility		
Inpatient and other Inpatient Services and Supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Outpatient	Coverage at the in-network cost share is limited to IOE only.	40% **coinsurance** after **deductible**
Physician services	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Mental Disorders Coverage is provided under the same terms, conditions as any other illness.		
Inpatient facility and other inpatient services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Residential Treatment Coverage is provided under the same terms, conditions as any other illness.		
Inpatient facility and other inpatient services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Mental Disorders Coverage is provided under the same terms, conditions as any other illness.		
Outpatient visits to a **Physician** or **Behavioral Health Provider**	$50 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Partial Hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)		
Substance Abuse		
Detoxification Coverage is provided under the same terms, conditions as any other illness.		
Outpatient	$50 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Partial hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)		
Rehabilitation Coverage is provided under the same terms, conditions as any other illness		
Inpatient and other inpatient services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Residential Treatment Coverage is provided under the same terms, conditions as any other illness.		
Inpatient facility and other inpatient services and supplies	20% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Rehabilitation Coverage is provided under the same terms, conditions as any other illness.		
Outpatient	$50 **copay** no **deductible** applies	40% **coinsurance** after **deductible**
Partial Hospitalization Treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for treatment of **Substance Abuse** provided under the direction of a **Physician**. **Intensive Outpatient Program** (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program for treatment of **Substance Abuse** provided under the direction of a **Physician.**		

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Pediatric Dental

Coverage is limited to covered persons through the end of the month in which the person turns 19

Type A Services	0% no **deductible** applies	0% no **deductible** applies
Type B Services	30% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**
Type C Services	40% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Orthodontic Services	40% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**
Dental Emergency Limit:	$75	$75

The dental emergency limit is the most the plan will pay for health care services incurred by you for any one dental emergency.

Dental benefits are subject to the medical plan's **Deductibles** and M**aximum Out-of-Pocket Limits** as explained on the Schedule of Benefits.

Type A Services: Diagnostic and Preventive Care

Visits and images

- Office visit during regular office hours, for oral examination (limited to: 2 visits every 12 months)
- Routine comprehensive or recall examination (limited to: 2 visits every 12 months)
- Problem-focused examination (limited to: 2 visits every 12 months)
- Prophylaxis (cleaning) (limited to: 2 treatments per year)
- Topical application of fluoride, (limited to: 2 courses of treatment per year)
- Sealants, per tooth (limited to: one application every 3 years for permanent molars)
- Bitewing images (limited to: 2 sets per year)
- Complete image series, including bitewings if **medically necessary** (limited to: 1 set every 3 years)
- Panoramic film (limited to: 1 set every 3 years)
- Vertical bitewing images (limited to: 2 sets per year)
- Periapical images
- Intra-oral, occlusal view, maxillary or mandibular
- Emergency palliative treatment per visit

Space maintainers

- Only when needed to preserve space resulting from premature loss of primary teeth (includes all adjustments within 6 months after installation)
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Re-cementation of space maintainer

Type B Services: Basic Restorative Care

Visits and images

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Consultation (by other than the treating provider)

Images and pathology

- Upper or lower jaw, extra-oral

Oral surgery

- Extractions
  - Erupted tooth or exposed root

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

- Coronal remnants
- Surgical removal of erupted tooth/root tip

- Impacted teeth
- Removal of tooth (soft tissue)
- Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)
  - Removal of impacted tooth-completely boney impacted with unusual surgical complications
  - Surgical removal of residual tooth roots
  - Surgical access of an unerupted tooth
- Odontogenic cysts and neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other surgical procedures
- Alveoplasty, in conjunction with extractions - per quadrant
- Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- Alveoplasty, not in conjunction with extraction - per quadrant
- Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
- Sialolithotomy: removal of salivary calculus
- Closure of salivary fistula
- Excision of hyperplastic tissue
- Removal of exostosis
  - Tooth reimplantation
- Incision and drainage of abscess
- Transplantation of tooth or tooth bud
- Closure of oral fistula of maxillary sinus
- Sequestrectomy
- Crown exposure to aid eruption
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury

Periodontics
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)

- Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Periodontal maintenance procedures following active therapy (limited to: 4 in 12 months (combined with prophylaxis after completion of active periodontal therapy))
- Localized delivery of antimicrobial agents

Endodontics
- Pulp capping
- Pulpotomy
- Pulpal therapy

Restorative dentistry
Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges
(Multiple restorations in 1 surface will be considered as a single restoration.)
- Amalgam restorations

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
- Prefabricated stainless steel
- Prefabricated resin crown (excluding temporary crowns)
- Re-cementation
    - Inlay
    - Crown
    - Bridge

Prosthodontics
Dentures and partials

- Office reline
- Laboratory relines
- Special tissue conditioning, per denture
- Rebase, per denture
- Recement fixed partial denture
- Adjustment to denture (more than 6 months after installation)
- Full and partial denture repairs
    - Broken dentures, no teeth involved
    - Repair cast framework
    - Replacing missing or broken teeth, each tooth
    - Adding teeth to existing partial denture
        - Each tooth
        - Each clasp
- Repairs: bridges; partial dentures

General anesthesia and intravenous sedation

- Only when medically necessary and only when provided in conjunction with a covered dental surgical procedure

Type C Services: Major Restorative Care

Periodontics

- Osseous surgery, including flap and closure, 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Osseous surgery, including flap and closure, per quadrant (limited to 1 per quadrant every 3 years)
- Soft tissue graft procedures
- Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
- Gingivectomy, 1 to 3 teeth per quadrant
- Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
- Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
- Clinical crown lengthening
- Full mouth debridement (limited to 1 treatment per lifetime)

Endodontics

- Apexification/recalcification
- Apicoectomy

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

- Pulpal regeneration
- Root canal therapy including medically necessary images:
  - Anterior
  - Bicuspid
  - Molar
- Retreatment of previous root canal therapy including medically necessary images:
  - Anterior
  - Bicuspid
  - Molar

Root amputation
Hemisection (including any root removal)

Restorative

- Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to: 1 per tooth every 5 years).
- Inlays/Onlays
- Crowns(limited to: 1 tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
  - Titanium
  - Post and core
- Core build-up

Prosthodontics

- Installation of dentures and bridges is covered only if needed to replace teeth which were not abutments to a denture or bridge less than 5 years old.
- Replacement of existing bridges or dentures (limited to: 1 every 5 years.)
- Bridge abutments (See Inlays/Onlays and Crowns) (limited to: 1 tooth every 5 years)
- Pontics (limited to: 1 tooth every 5 years)
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
  - Titanium
- Removable Bridge (unilateral) (limited to: 1 every 5 years)
- One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics (limited to: 1 every 5 years)
- Dentures and Partials-limited to 1 every 5 years (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible)
  - Complete upper denture

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

- Complete lower denture
- Immediate upper denture
- Immediate lower denture
- Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- Surgical Placement of interim Implant Body
- Eposteal Implant
- Transosteal Implant, including hardware
- Connecting Bar – implant or abutment supported
- Abutment supported retainer for porcelain/ceramic fixed partial denture
- Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
- Abutment supported retainer for porcelain fused to predominately based metal fixed partial denture
- Abutment supported retainer for porcelain fused to noble metal fixed partial denture
- Abutment supported retainer for cast high noble metal fixed partial denture
- Abutment supported retainer for predominately based metal fixed partial denture
- Abutment supported retainer for cast noble metal fixed partial denture
- Implant supported retainer for ceramic fixed partial denture
- Implant supported retainer for porcelain fused to high noble metal fixed partial denture
- Implant supported retainer for cast metal fixed partial denture
- Implant Maintenance Prosthesis
- Repair Implant Prosthesis
- Replacement of Semi-Precision or Precision Attachment
- Repair Implant Abutment
- Implant Removal
- Implant Index
- Retainer – cast metal for resin bonded fixed prosthesis
- Retainer – porcelain/ceramic for resin bonded fixed prosthesis

- Implants (Only if determined as a dental necessity and limited to 1 every 5 years)
- Implant supported complete denture, partial denture (limited to 1 every 5 years)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Office reline
- Laboratory reline
- Special tissue conditioning, per denture
- Rebase, per denture
- Adjustment to denture more than 6 months after installation
- Full and partial denture repairs
- Broken dentures, no teeth involved
- Repair cast framework
- Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Occlusal guard, patients age 13 and older

Orthodontic services

- **Medically Necessary** comprehensive treatment
- Replacement of retainer (limited to: 1 per lifetime)

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

	Deductible/Copayment/Coinsurance/Maximums	
Eligible Health Services	**In-Network Coverage***	**Out-of-Network Coverage***
9. Outpatient Prescription Drugs		
Plan features	**Deductible/Copayment/Coinsurance/Maximums**	
Deductible and Copayment or Coinsurance waiver for Risk Reducing Breast Cancer		
The Calendar Year **Deductible** and the per **prescription Copayment** or **Coinsurance** will not apply to risk reducing breast cancer **Prescription Drugs** when obtained at a **network pharmacy**. This means that such risk reducing breast cancer **Prescription Drugs** will be paid at 100%.		
Deductible and Copayment or Coinsurance Waiver for Tobacco Cessation Prescription and Over-the-Counter Drugs		
The Calendar Year **Deductible** and the per **prescription Copayment** or **Coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **Prescription Drugs** and OTC drugs when obtained at a **retail network pharmacy**.This means that such **Prescription Drugs** and OTC drugs will be paid at 100%.		
Deductible and Copayment or Coinsurance Waiver for Contraceptives		
The Calendar Year **Deductible** and the per **prescription Copayment** or **Coinsurance** will not apply to female contraceptive methods when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100% for: • The following female oral and injectable contraceptives that are **Generic Prescription Drugs**: – Oral drugs – Injectable drugs – Vaginal rings – Transdermal contraceptive patches • Female contraceptive devices that are generic devices and brand-name devices • FDA approved female: - Generic emergency contraceptives - Generic over-the-counter (OTC) emergency contraceptives The Calendar Year **Deductible** and the per **prescription Copayment** or **Coinsurance** continue to apply to **Prescription Drugs** that have a generic equivalent, biosimilar or generic alternative available within the same **therapeutic drug class** obtained at a **network pharmacy** unless you are granted a medical exception.		

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Eligible Health Services	In-Network Coverage*	Out-of-Network Coverage*
Per prescription Copayment or Coinsurance		
Tier 1A - Value Drugs		
For each 30 day supply filled at a **retail pharmacy**	$3 **copay**	$3 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$7.50 **copay**	Not covered
Tier 1 -- Preferred Generic Prescription Drugs		
For each 30 day supply filled at a **retail pharmacy**	$15 **copay**	$15 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy or mail order pharmacy**	$37.50 **copay**	Not covered
Tier 2 -- Preferred Brand-Name Prescription Drugs		
For each fill up to a 30 day supply filled at a **retail pharmacy**	$40 **copay**	$40 **copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$100 **copay**	Not covered

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Tier 3 -- Non-Preferred Generic and Brand-Name Prescription Drugs		
For each 30 day supply filled at a **retail pharmacy**	$70 **copay**	$70**copay**
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **retail pharmacy** or **mail order pharmacy**	$175 **copay**	Not covered
Tier 4 -- Preferred Specialty Care Prescription Drugs(Including Biosimilar Prescription Drugs)		
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	30% up to $250 per **prescription**	30% up to $250 per **prescription**
Tier 5 – Non-Preferred Specialty Care Prescription Drugs(Including Biosimilar Prescription Drugs)		
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	40% up to $500 per **prescription**	40% up to $500 per **prescription**
Diabetic Prescription Drugs, Supplies and Insulin		
For each 30 day supply filled at a **retail pharmacy**	Paid according to the tier of drug per the Schedule of Benefits, above	Paid according to the tier of drug per the Schedule of Benefits, above
For all fills greater than a 30 day supply but no more than a 90 day supply filled at a **mail order pharmacy**	Paid according to the tier of drug per the Schedule of Benefits, above	Paid according to the tier of drug per the Schedule of Benefits, above

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

Orally Administered Anti-Cancer Medications		
For each 30 day supply filled at a **retail pharmacy** or specialty **network pharmacy**	Paid according to the tier of drug per the Schedule of Benefits, above	Paid according to the tier of drug per the Schedule of Benefits, above
Outpatient Prescription Contraceptive Drugs and Devices		
Female contraceptives that are **Generic Prescription Drugs.** For each 30 day supply: • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	$0 per **Prescription** or refill	$15 **copay**
Female contraceptives that are **Brand- Name Prescription Drugs.** For each 30 day supply: • Oral drugs • Injectable drugs • Vaginal rings* • Transdermal contraceptive patches	Paid according to the tier of drug per the Schedule of Benefits, above *Brand-name vaginal rings covered at 100% to the extent that a generic is not available	Paid according to the tier of drug per the Schedule of Benefits, above
Female contraceptive **generic** devices and **brand name** devices. For each 30 day supply	0% per **Prescription** or refill	Paid according to the tier of drug per the Schedule of Benefits, above
FDA-approved female **generic** and **brand-name** emergency contraceptives. For each 30 day supply	0% per **Prescription** or refill	Paid according to the tier of drug per the Schedule of Benefits, above
FDA-approved female **generic** and **brand-name** over-the-counter emergency contraceptives. For each 30 day supply	0% per **Prescription** or refill	Paid according to the tier of drug per the Schedule of Benefits, above
Preventive Care Drugs and Supplements		

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits

For each 30 day supply filled at a **retail pharmacy**	0% per **Prescription** or refill	Paid according to the tier of drug per the Schedule of Benefits, above
Maximums: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto the Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of the your ID card.		
Risk Reducing Breast Cancer Prescription Drugs		
For each 30 day supply filled at a **retail pharmacy**	0% per **Prescription** or refill	Paid according to the tier of drug per the Schedule of Benefits, above
Maximums: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer **Prescription Drugs**, contact Member Services by logging onto the Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of the your ID card.		
Tobacco Cessation Prescription and Over-the-Counter Drugs		
For each 30 day supply filled at a **retail pharmacy**	$0 per **Prescription** or refill No **Calendar Year Deductible** applies	Paid according to the tier of drug per the Schedule of Benefits, above
Maximums: • Coverage is permitted for two, 90-day treatment regimens only. Any additional treatment regimens will be paid according to the tier of drug per the schedule of benefits, above • Coverage only includes generic drug when a brand-name drug is available. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **Prescription Drugs** and OTC drugs, contact Member Services by logging onto the Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of the your ID card.		
Important Note: See the *Outpatient Preventive Care Drugs and Supplements and Risk Reducing Breast Cancer Prescription Drugs* section for more information on other **Prescription Drug** coverage under this plan.		
If the **Member** or the **Member's prescriber** requests a covered **Brand-Name Prescription Drug** when a covered **Generic Prescription Drug** equivalent is available, the **Member** will be responsible for the cost difference between the **Generic Prescription Drug** and the **Brand-Name Prescription Drug**, plus the cost sharing that applies to **Brand-Name Prescription Drugs.** The cost difference that you pay is not applied toward the **Calendar Year Prescription Drug Deductible** or **Maximum Out-of-Pocket Limit**.		

*See How to read the Schedule of Benefits at the beginning of this Schedule of Benefits