

BENEFIT PLAN

**Prepared Exclusively For
State Of Alaska**

**Political Subdivisions - Option IV
Open Choice (PPO) Medical, Vision,
Pharmacy, Dental and Hearing**

**Aetna Life Insurance Company
Booklet-Certificate**

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

**What Your Plan
Covers and How
Benefits are Paid**

aetnaSM

ID Cards

If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. If you still would like an ID card for you and your dependents, you can print a customized ID card by going to the secure member website at www.aetna.com. You can also access your benefits information when you're on the go. To learn more, visit us at www.aetna.com/mobile or call us at 1-877-238-6200.

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*Defines the Terms Shown in Bold Type in the Text of This Document.

Preface (GR-9N-02-005-01 AK)

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.

Group Policyholder:	State Of Alaska
Group Policy Number:	GP-392675
Effective Date:	July 1, 2014
Issue Date:	July 3, 2014
Booklet-Certificate Number:	1 (Option IV)



Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

Important Information Regarding Availability of Coverage (GR-9N 02-005 02)

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 (GR-9N-02-005-01 AK)

Health Expense Coverage (GR-9N-02-020-01 AK)

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.

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

Treatment Outcomes of Covered Services (GR-9N-02-020-01 AK)

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.

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 (GR-9N-29-005-02)

You are in an eligible class if:

- You are a permanent, full-time employee, of a participating political subdivision (those who work 30 or more hours per week on a regular basis);
- You are a permanent part-time employee of a participating political subdivision who elects to participate in the plan (those who work at least 15 but less than 30 hours per week on a regular basis); or
- You are an elected official receiving a salary from a participating political subdivision.

Probationary Period (GR-9N-29-005-02)

Once you enter an eligible class, you will need to complete the probationary period 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 this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan (Permanent full-time and permanent part-time employees)

If you are hired or enter an eligible class after the effective date of this plan, your coverage eligibility date is the 31st consecutive day you are in pay status. This is defined as the probationary period. If you had already satisfied the plan's probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

If you were previously covered under the plan and you are rehired within seven calendar days after your coverage terminated by your former employer or another employer participating in the plan, your coverage eligibility date is the date you are rehired. If you are rehired more than seven calendar days after your coverage terminated, your coverage eligibility date is the 31st consecutive day you are in pay status.

After the Effective Date of the Plan (Elected officials)

If you enter an eligible class after the effective date of this plan, your coverage eligibility date is the date you are sworn into office.

Obtaining Coverage for Dependents (GR-9N-29-010-02)

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

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

Aetna will rely upon the policyholder 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 (GR-9N 29-010 01)

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 (GR-9N-29-010-08 AK)

To be eligible for coverage, a dependent child must be under 26 years of age.

(GR-9N-29-010-08 AK)

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

How and When to Enroll (GR-9N 29-015-02)

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. 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 for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions 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.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Newborns are automatically covered for 60 days after birth. To continue coverage after 60 days, you will need to complete a change form and return it to your employer within the 60-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.

Late Enrollees are subject to the Preexisting Condition Limitation.

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 *(GR-9N 29-015-HRPA)*

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 *(GR-9N-29-015-05-AK)*

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 other **creditable coverage**; 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 **creditable coverage**; and
- You or your dependents are no longer eligible for other **creditable coverage** because of one of the following:
 - The end of 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;
 - Death;
 - Divorce or legal separation;
 - Employer contributions toward that coverage have ended;
 - COBRA coverage ends;
 - The employer’s decision to stop offering the group health plan to the eligible class to which the employee belongs;
 - Cessation of a dependent’s status as an eligible dependent as such is defined under this Plan; or
 - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage;
 - The operation of another Plan's lifetime maximum on all benefits, if applicable.

You or your dependents become eligible for State 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:

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

Evidence of termination of **creditable 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 31 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 31 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 31 days of the change. If you do not return the form within 31 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 provide coverage for a newly adopted child or a child who is placed for adoption* if the child meets the plan's definition of an eligible dependent on the date he or she is adopted or placed for adoption.

The child's coverage will begin on the date of the adoption or placement.

To continue the child's coverage beyond this 31-day period, you must:

- Request coverage for the child in writing within 31 days of the adoption or placement.
- Proof of the adoption or placement to **Aetna**.

Also, any coverage limitations for a **pre-existing 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.

* This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

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 31 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 31-day period.

If you do not request coverage for the child within the 31-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 (GR-9N-29-025-01 AK)

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; or
- The date your enrollment form is received; and
- The date your required contribution is received by **Aetna**.

If your completed enrollment information is not received 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 (GR-9N 29-025-02)

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

(GR-9N-08-005-01)

Common Terms

Accessing Providers

Precertification

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 (GR-9N-08-010-01)

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 PPO Comprehensive Medical Plan (GR-9N-08-020-01)

This 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 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 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 PPO plan is designed to lower your out-of-pocket costs when you use **network providers** for **covered expenses**. Your **deductibles, copayments**, and payment percentage will generally be lower when you use participating **network providers** and facilities.

You also have the choice to access licensed **providers, hospitals** and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. **Deductibles, copayments**, and **coinsurance** are 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.

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 benefits, 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 Complaints and Appeals Health Amendment included with this Booklet-Certificate.

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

How Your PPO Plan Works (GR-9N-08-025 03)

Accessing Network Providers and Benefits

- You may select any **network provider** from the **Aetna network provider directory** or by logging on to **Aetna's** website 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 health care provider at any time.
- If a service you need is covered under the plan but not available from a **network provider**, please contact Member Services 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 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** less any cost sharing required by you. You will be responsible for **deductibles, coinsurance**, and **copayment**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe toward your **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. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

Important Note:

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

- You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- For certain types of services and supplies, you will be responsible for any **copayment** shown in the *Schedule of Benefits*.
- After you satisfy any applicable **deductible**, you will be responsible for your **coinsurance** for **covered expenses** that you incur. 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 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 your *Schedule of Benefits* section for information on the specific **limits** that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.
- You may be billed for any **deductible, copayments, or coinsurance** amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

- You have the choice to directly access **physicians, hospitals or other health care** providers that do not participate with the **Aetna provider network**. You will still be covered when you access **out-of-network providers** for **covered benefits**. Your out-of-pocket costs will generally be higher. However, if you must obtain services from an **out-of-network provider** because there is not a **network provider** in your area, please contact Member Services at the number shown on your ID card so that your **covered expenses** may be paid at the **network** level.
- **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**.
- **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 or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **physicians** and **hospitals** that are not in the **network** you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an **out-of-network provider**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**.
- You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your **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** will result in a reduction of benefits under this Booklet-Certificate. Please refer to the *Understanding Precertification* section for information on how to **precertify** and the **precertification** benefit reduction.

Cost Sharing for Out-of-Network Benefits

Important Note:

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

- You must satisfy any **deductibles** before the plan begins to pay benefits.
- 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* section for information on what expenses do not apply and for the specific dollar limits that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* section. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or the *Schedule of Benefits* sections.

Understanding Precertification

Precertification

Inpatient **stays** 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 provided by a **network provider**. **Network providers** will be responsible for obtaining 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.

When you go to an **out-of-network provider**, it is your responsibility to obtain **precertification** from **Aetna** for any services on the **precertification** list below. If you do not **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

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** there are certain **precertification** procedures that must be followed.

You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission 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 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 .

Aetna will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

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** is not a **covered expense**, 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 Amendment included with this Booklet-Certificate.

Services and Supplies Which Require Precertification (GR-9N-08-065-04 AK)

Precertification is required for the following types of medical expenses:

Inpatient Care

- Stays in a hospital
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse.

How Failure to Precertify Affects Your Benefits (GR-9N 08-070-01)

A **precertification** benefit reduction will be applied to the benefits paid if you fail to obtain a required **precertification** prior to incurring medical expenses. 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.

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 **deductible** or **Maximum Out-of-Pocket Limit**.

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

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 **network provider** or **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **network provider** or **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **network provider** or **physician** as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, your benefits will be reduced. 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 pay a reduced benefit, 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 (GR-9N-27-010-01)

Call your **network provider** or **physician** 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 **network provider** or **physician**, please do so as soon as possible after urgent care is provided. If you need help finding a **network urgent care provider** 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.

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** 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 for follow-up care, your coverage will be reduced and you will be responsible for more of the 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 **provided by a** network provider. However, if a **network provider** is not available in your area, please call Member Services at the toll-free number on your I.D. card so that your expenses will be paid at the **network** level.

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 (GR-9N-09-005-01 AK)

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 *Exclusions* sections of this Booklet-Certificate for a list 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* section 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.
3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical or dental services, supply or **prescription drug** must be provided by a **physician**, or other health care provider or **dental 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 or dental 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 **dental provider** 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 or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed medical or dental literature generally recognized by the relevant medical or dental community, or otherwise consistent with **physician** or dental specialty society recommendations and the views of **physicians** or **dentists** 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 medical or dental 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* section and the *Schedule of Benefits* for the plan limits and maximums.

What The Plan Covers

(GR-29N 11-05 01)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

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

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

Important Notes:

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

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

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

Routine Physical Exams

Covered expenses include charges made by your **physician** for routine physical exams. 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:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

Covered expenses for children from birth to age 18 also include:

- An initial **hospital** check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

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

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

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

Routine Cancer Screenings

Covered expenses include charges incurred for routine cancer screening as follows:

- One baseline mammogram for women between the ages of 35-40;
- One routine mammogram once every two years for women between the ages of 40-50 and once each year for women age 50 and over;
- One routine Pap smear each Calendar Year; and
- One routine prostate cancer screening test each year consisting of a specific antigen blood test (or any other test that is equivalent or better in cancer detection) for a male age 35 or over, including a male age 35 through 39 who is at high risk for prostate cancer;
- A gynecological exam each Calendar Year. This includes a rectovaginal pelvic exam for women age 25 and over who are at risk of ovarian cancer;
- Colorectal cancer screenings for covered persons who are:
 - 50 years of age or older; or
 - under age 50 and are at high risk for colon cancer.

The minimum colorectal cancer screening and laboratory testing will always be in accordance with the American Cancer Society's colorectal cancer screening guidelines. They currently include:

- One fecal occult blood test (FOBT) or one fecal immunochemical test (FIT) every year.
- One flexible sigmoidoscopy every 5 years.
- One digital rectal exam each year.
- One double contrast barium enema (DCBE) every 5 years.
- One colonoscopy every 10 years.

The covered person, in consultation with his/her **physician** or other health care provider, will make the final decisions as to which of the above test(s) will be performed.

Family Planning Services (GR-29N 11-05 01)

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an **illness** or **injury**. Refer to the *Schedule of Benefits* for any frequency limits that apply to these services, if not specified below.

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
 - Consultations;
 - Exams;
 - Procedures; and
 - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Also see section on pregnancy and infertility related expenses on a later page.

Phenylketonuria (PKU) Services

This plan will provide coverage for expenses incurred by a covered person for:

- formulas; and
- special food products.

for the treatment of phenylketonuria.

“Formula” means an enteral product intended for the dietary treatment of phenylketonuria under the direction of a **physician**.

Vision Care Services (GR-9N S-11-010-01)

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 12 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year **deductibles, copays** and **coinsurance** percentages shown in your *Schedule of Benefits*.

Hearing Exam (GR-9N 11-015-01)

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
 - Is legally qualified in audiology; or
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible, copay** and **coinsurance** shown in your *Schedule of Benefits*.

Physician Services (GR 9N S 11-20 02)

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:

- Immunizations for infectious disease, but not if solely for your employment,
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

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 the Plan Works* for more information about **precertification**.

Alternatives to Physician Office Visits (GR-9N 11-020 02)

Walk-In Clinic Visits

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

Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

Hospital Expenses (GR-9N-11-030 01)

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.
- 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 (GR-9N-11-030 01)

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.

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

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your **stay**.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits.

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 **network provider** or **physician** 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 pay a reduced benefit, 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 provider** 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;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

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

Alternatives to Hospital Stays (GR-9N-11-040-01)

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.

Birth Center

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 maternity care.

Home Health Care (GR-9N-11-050-01)

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 four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. 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 (three 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.

Benefits for home health care visits are payable up to the Home Health Care Maximum.

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.

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 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 *How the Plan Works* for details about **precertification**.

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

Private Duty Nursing (GR-9N S-11-065-01)

Covered expenses include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing** care and visiting nursing care is not adequate. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

Limitations

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

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
 - Transportation;
 - Meal preparation;
 - Vital sign charting;
 - Companionship activities;
 - Bathing;
 - Feeding;
 - Personal grooming;
 - Dressing;
 - Toileting; and
 - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

Skilled Nursing Facility (GR-9N-S-11-060-01)

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.

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 (GR-9N-S-11-070-01 AK)

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.

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 the Plan Works* for details about **precertification**.

Other Covered Health Care Expenses (GR-9N-11-080-01 AK)

Acupuncture

The plan covers charges made for acupuncture services provided by a **physician or a licensed acupuncturist**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

Ambulance Service (GR-9N-11-080-01)

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 (GR-9N-11-085-01)

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);

- 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 and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), 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.

Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductible**, **coinsurance** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

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 complex imaging 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) (GR-9N 11-090-01)

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 will be made by **Aetna**.

Important Reminder

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, coinsurance** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

Experimental or Investigational Treatment

Covered expenses include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided **all** of the following conditions are met:

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

Pregnancy Related Expenses (GR-9N-11-100-01)

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.

Prosthetic Devices (GR-9N 11-110-01)

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.

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 Rehabilitation Therapy Services (GR-9N-11-120-01)

Covered expenses include charges for short-term therapy services when prescribed by a **physician** as described below 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**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

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

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 Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. 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 **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for 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 therapy associated with physical 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.

A "visit" consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Important Reminder

Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

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

- 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. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's syndrome, and Cerebral Palsy, 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 for the treatment of delays in speech development, unless resulting from **illness, injury**, or congenital defect;
- Services provided during a **stay** in a **hospital, skilled nursing facility, 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.

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*.

Specialized Care (GR-9N-11-135-01 AK)

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 charges made on an outpatient basis for infusion therapy by:

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

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).

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 *Inpatient 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 Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** and maximum benefit limits.

Diabetic Equipment, Supplies and Education (GR-9N-11-135-01 AK)

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

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training/education provided by a licensed health care provider certified in diabetes self-management training;
- Medical nutrition therapy provided by a licensed health care provider certified in medical nutrition therapy; and
- Foot care to minimize the risk of infection.

Treatment of Infertility (GR-9N-11-135-01 AK)

Basic Infertility Expenses

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

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.

Transplant Services (GR-9N 11-160-01)

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:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

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 the 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;
- 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.

Treatment of Mental Disorders and Substance Abuse (GR-9N-11-172-01 AK)

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of **mental disorders** by **behavioral health providers**.

Important Note

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

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a **behavioral health provider**;
- This Plan includes follow-up treatment; and
- This Plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

Inpatient Treatment

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

Important Reminder

Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Outpatient Treatment

Covered expenses include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Important Reminder

- Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **Maximum Out-of-Pocket Limit** that may apply to your **mental disorders** benefits.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of **substance abuse** by **behavioral health providers**.

Important Note

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

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
 - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
 - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles**, maximums and Maximum Out-of-Pocket Limit that may apply to your **substance abuse** benefits.

Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- “Medical complications” include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

Important Reminder

Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital, psychiatric hospital or residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

Partial Confinement Treatment

Covered expenses include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

Important Reminders:

- Inpatient care must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and Maximum Out-of-Pocket Limit that may apply to your **substance abuse** benefits.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (GR-9N 11-180-01)

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:

- (a) Natural teeth damaged, lost, or removed; or
- (b) 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**.

Medical Plan Exclusions (GR-9N-28-015-07)

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. 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 Note:

You have medical and prescription drug, dental and vision insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug, dental and vision 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 incurred outside of the United States if you traveled to such location to obtain medical services, **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** 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.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

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.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to 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: 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.

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:

- 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 drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder; 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;
 - to 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.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

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's primary residence or providing primarily custodial or rest care;

- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food items: 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. Please Note: This exclusion will not apply to formulas and special food products needed for the treatment of phenylketonuria (PKU).

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.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

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 unless they are provided by a health care provider acting within the scope of his or her license.

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.

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** 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**.

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, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

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

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

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.

Smoking: 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.

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.

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 Medical Plan Covers Section*. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

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.

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. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

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.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting 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. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- 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 provided by this Booklet-Certificate, 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.

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 Aetna Vision Expense Plan (GR-9N-22-005-02-AK)

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

- Definitions you need to know;
- How to access services, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What 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.

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 vision care expenses are covered under the plan. Exclusions and limitations apply to certain services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions* and *Schedule of Benefits* sections to determine what expenses are covered, excluded or limited.

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 vision expense plan.
- Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms (GR-9N 22-010 01)

You will find terms 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*.

About the Basic Vision Expense Plan (GR-9N-22-015-01)

Using the Plan

The Basic Vision Expense plan will pay for **covered expenses**, up to the maximums shown in the *Schedule of Benefits*.

- You can directly access **physicians** and other vision care providers of your choice for covered vision services and supplies under the plan.
- You may have to pay the **provider** or facility full charges and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the provider. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **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.

Cost Sharing

Important Note:

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

- You must satisfy any **deductibles** before the plan begins to pay benefits.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur.
- 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**.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

Basic Vision Expense Plan (GR-9N-24-005-02 AK) (GR-9N-24-010-02 AK)

What the Plan Covers

This plan covers charges for certain vision care supplies described below. The plan limits coverage to a maximum benefit amount per benefit period. Refer to your *Schedule of Benefits* to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the *Schedule of Benefits*.

What the Plan Covers

This plan covers charges for certain vision care exams and supplies described in this section. The plan limits coverage to a maximum benefit amount per benefit period. Refer to your *Schedule of Benefits* to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the *Schedule of Benefits*.

Vision Supplies

This plan covers charges for lenses and frames, or prescription contact lenses when prescribed by a legally qualified ophthalmologist or optometrist, as follows:

Prescription Lenses

Covered expenses include **prescription** lenses prescribed for the first time and new lenses required due to a change in **prescription** up to the benefit maximum, listed in your *Schedule of Benefits*. Charges for **prescription** contact lenses will be covered in an amount equal to the amount that would be covered for single vision lenses, as shown in your *Schedule of Benefits*.

Benefits are payable up to the Prescription Lenses Maximum, per benefit period, listed in your *Schedule of Benefits*.

Covered expenses also include

- Aphakic lenses prescribed after cataract surgery; and
- contact lenses required to correct visual acuity to 20/70 or better in the better eye if such correction cannot be made with conventional lenses.

Benefits for these lenses are payable up to the Aphakic and Contact Lens Benefit Maximum, per benefit period, listed on the *Schedule of Benefits*. You are responsible for any cost-sharing amounts listed in the *Schedule of Benefits*.

Frames

Covered expenses include expenses for frames if the lenses for them are covered under this section.

Eyeglass frames are covered when purchased with **prescription** lenses up to the Eyeglass Frames Maximum, per benefit period, listed in your *Schedule of Benefits*.

Limitations

All **covered expenses** are subject to the vision expense exclusions in this Booklet-Certificate and are subject to the **deductible(s), copayments or coinsurance** listed in the *Schedule of Benefits*, if any.

Coverage is subject to the exclusions listed in the *Vision Care Exclusions* section of this Booklet-Certificate.

Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in **prescription**.

Coverage is subject to the benefit maximums described above and in your *Schedule of Benefits*.

Vision Plan Exclusions (GR-9N-28-030-02-AK)

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. 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 vision exclusions are in addition to the exclusions listed under your medical coverage.

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

Any exams given during your **stay** in a **hospital** or other facility for medical care.

Drugs or medicines.

Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.

For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.

For an eye exam.

Prescription or over-the-counter drugs or medicines.

Special vision procedures, such as orthoptics, vision therapy or vision training.

Vision service or supply which does not meet professionally accepted standards.

Anti-reflective coatings.

Tinting of eyeglass lenses.

Duplicate or spare eyeglasses or lenses or frames for them.

Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.

Replacement of lost, stolen or broken **prescription** lenses or frames.

Special supplies such as nonprescription sunglasses and subnormal vision aids.

Vision services that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder; or
- Under any workers' compensation law or any other law of like purpose.

Your Pharmacy Benefit (GR-9N-12-005-02)

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.

(GR-9N-12-005-02 AK)

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.
- You will receive out-of-**network** coverage for **prescription drugs** obtained at an **out-of network pharmacy**. However, if a **Network Pharmacy** is not located in your service area, payment for your covered prescription drugs will be paid at the Network level.

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-Named Prescription Drug is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**, an affiliate or third party vendor.

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 as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. These drugs are identified by Medispan or any other publication designated by **Aetna**, an affiliate or third party vendor.

Network pharmacy is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you

and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

Non-Preferred Drug (Non-Formulary) is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

Out-of-network pharmacy is a description of 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 **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

Preferred Drug Guide is a listing of **prescription drugs** established by **Aetna**, an affiliate or third party vendor, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and changes by **Aetna**, an affiliate or third party vendor. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at www.aetna.com/formulary.

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 with the scope of their license.

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.

Specialty Pharmacy Network. **Aetna’s** network of participating pharmacies designated to fill **Self-injectable Drug** prescriptions.

Accessing Pharmacies and Benefits (GR-9N-S-12-015-02 AK)

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.

Your plan **will** pay for outpatient **prescription drugs** you obtain from either a **network pharmacy** or an **out-of-network pharmacy**. **Prescription drugs** obtained from a **network pharmacy** will be paid at the network level and those obtained from an **out-of-network pharmacy** will be paid at the out-of-network level. However, if a **Network Pharmacy** is not located in your area, payment for your covered expenses will be paid at the Network level.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you

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

Accessing Network Pharmacies and Benefits (GR-9N-12-015-02)

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 (GR-9N-S-12-015-02 AK)

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 for **network** benefits.

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 need to satisfy any applicable **deductibles** before the plan will begin to pay 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 satisfy any applicable **deductible** and 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 (GR-9N-S-13-005-02 AK)

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 need to satisfy any applicable calendar year **deductibles** before the plan will begin to pay benefits.

- After you satisfy any applicable year **deductible(s)**, 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**.

Pharmacy Benefit (GR-9N-S-13-005-02 AK)

What the Plan Covers

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

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. The **preferred drug guide** includes both **brand-name prescription drugs** and **generic prescription drugs**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

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

(GR-9N-S-13-005-02 AK)

Coverage of **prescription drugs** may be subject to **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your **provider** and/or your **network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

All prescriptions and refills over a 30 day supply must be filled at a **mail order pharmacy**.

Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **mail order pharmacy**. **Prescriptions** for 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**.

Injectable, Self-Injectable and Specialty Drug Benefits

Injectable, **Self-injectable** and Specialty Care **drugs** are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. Refer to the **preferred drug guide** for a list of **self-injectable** and specialty care **drugs**. You may refer to **Aetna's** website, www.aetna.com to review the list anytime. The list may be updated from time to time.

The initial prescription for an injectable, **self-injectable**, and **specialty care drug** must be filled at a **retail pharmacy** or at **Aetna's specialty pharmacy network**.

You may obtain injectable, **self-injectable** and **specialty care drugs** at **Aetna's specialty pharmacy network** or an out-of-network retail pharmacy for all prescription drug refills after the initial fill.

Each **prescription** is limited to a maximum 30 day supply when filled at **Aetna's specialty pharmacy network**.

Other Covered Expenses (GR-9N-S-13-005-02 AK)

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

Off-Label Use (GR-9N-S-13-005-02 AK)

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may be subject to **Aetna** requirements or limitations.

Diabetic Supplies (GR-9N-S-13-005-02 AK)

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

The following contraceptives and contraceptive devices:

- Oral Contraceptives.
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives.
- Contraceptive patches.
- Contraceptive rings.
- Implantable contraceptives and IUDs are covered when obtained from a **physician**. The **physician** will provide insertion and removal of the drugs or device.

Oral Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Progesterone.

Pharmacy Benefit Limitations (GR-9N-S-13-15-01-AK)

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.

Aetna will also cover **prescription drugs** obtained at an **out-of network pharmacy**. However, if a **Network Pharmacy** is not located in your area, payment for your covered expenses will be made at the Network level.

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.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

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

The number of **copayments/deductibles** 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.

Pharmacy Benefit Exclusions (GR-9N 28-020-01-AK)

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dentist** 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:

- Administration or injection of any drug;
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet-Certificate;
- Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) 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** 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**.

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

Contraception:

- Over the counter contraceptive supplies including but not limited to:
 - condoms;
 - contraceptive foams;
 - jellies; and
 - ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

Cosmetic drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, 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.

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

Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any **prescription drug** in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes including but not limited to:

- Sildenafil citrate;
- Phentolamine;
- Apomorphine;
- Alprostadil; or
- Any other **prescription drug** that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes.

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

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 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 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.

All drugs or medications in a **therapeutic drug class** if one of the drugs in that **therapeutic drug class** is not a **prescription drug**.

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: Any food item, including:

- infant formulas;
- nutritional supplements;
- vitamins;

- medical foods and other nutritional items, even if it is the sole source of nutrition, unless they are needed for the treatment of phenylketonuria (PKU).

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

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by **Aetna**;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the **specialty pharmacy network** is available upon request. You may also get a copy of the list on **Aetna's** website at www.aetna.com.

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

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

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

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

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 **prescriptions**.

Drugs, services and supplies given in connection with treatment of an **occupational injury or occupational illness**.

Smoking: 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. This includes medications, nicotine patches and gum.

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

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

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

- Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

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

Test agents except diabetic test agents.

How Your Aetna Dental Plan Works

(GR-9N 16-005-01)

Common Terms

What the Plan Covers

Rules that Apply to the Plan

What the Plan Does Not Cover

Understanding Your Aetna Dental Plan

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

- Definitions you need to know;
- How to access care, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What 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. You can refer to the Eligibility section for a complete definition of "you".

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive covered expenses that are not or might not be **covered expenses** under this dental plan.

Store this Booklet-Certificate in a safe place for future reference.

Getting Started: Common Terms (GR-9N 16-010-01)

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 the Comprehensive Dental Plan (GR-9N 16-030 01)

This dental plan covers a wide range of necessary dental services and supplies. You have the freedom to choose the **dental provider** of your choice.

The comprehensive dental 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**).

If your **dentist** charges more than the **recognized charge**, you must also pay any expenses above the **recognized charge**.

You must file a claim to receive reimbursement from the plan.

Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductibles**, **coinsurance** and maximum benefit limits.

Getting an Advance Claim Review (GR-9N-16-035-01)

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your **dentist** make informed decisions about the care you are considering.

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 \$500. 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 x-rays 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 *Benefits When Alternate Procedures Are Available* 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.

What The Plan Covers (GR-9N 18-005-01)

Comprehensive Dental Plan

Schedule of Benefits for the Comprehensive Dental Plan

Comprehensive Dental is merely a name of the benefits in this section. The plan does not pay a benefit for all dental care expenses 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.

Covered expenses include charges made by a **dentist** for the services and supplies that are listed in the dental care schedule as shown in the *Schedule of Benefits*.

The next sentence applies 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.

In that case, 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.

Dental Care Schedule

The dental care schedule is a list of dental expenses that are covered by the plan. There are several categories of **covered expenses**:

- Preventive
- Diagnostic
- Restorative
- Oral surgery
- Endodontics
- Periodontics

These covered services and supplies are grouped as Type A, Type B or Type C.

Comprehensive Dental Expense Coverage Plan (GR-9N 18-006-01)

(GR-9N-19-006-01)

The following additional dental expenses will be considered **covered expenses** for you and your covered dependent if you have medical coverage insured or administered by **Aetna** and have at least one of the following conditions:

- Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes

Additional Covered Dental Expenses

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

Payment of Benefits

The additional prophylaxis, the benefit will be payable the same as other prophylaxis under the plan.

The **plan coinsurance** applied to the other covered dental expenses above will be 100%. These additional benefits will not be subject to any frequency limits except as shown above or any Calendar Year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder (GR-9N-18-010-01)

The **deductible, coinsurance** and maximums that apply to each type of dental care are shown in the *Schedule of Benefits*.

Type A Expenses: Diagnostic and Preventive Care

Visits and X-Rays

Oral exams. This includes prophylaxis, scaling, and cleaning of teeth.

Topical application of sodium or stannous fluoride.

X-rays for diagnosis. Also other X-rays not to exceed one full mouth series in a Calendar Year.

Sealants for persons under age 18.

Type B Expenses: Basic Restorative Care

First installation of a space maintainer to replace any baby tooth which is lost prematurely.

Oral surgery.

Extractions.

Fillings.

General anesthetics given in connection with covered dental services.

Treatment of diseased periodontal structures.

Endodontic treatment. This includes root canal therapy.

Emergency palliative treatment.

Injection of antibiotic drugs.

Type C Expenses: Major Restorative Care

Inlays, gold fillings, or crowns. This includes precision attachments for dentures.

Implants

First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments.

Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met.

Repair or recementing of crowns, inlays, bridgework, or dentures.

Relining of dentures.

First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed.

Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. But, the "Prosthesis Replacement Rule" below must be met.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. But proof satisfactory to Aetna must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.
- The present denture or bridgework cannot be made serviceable. Also, it must be at least 5 years old.
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

Rules and Limits That Apply to the Dental Plan (GR-9N 20-005-01)

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

Alternate Treatment Rule (GR-9N-20-015-02 AK)

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.

Significant alterations to your proposed treatment plan will be reviewed by a **dentist** who is licensed to practice dentistry in the state when the services will be performed.

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 Begun Before You Are Covered by the Plan (GR-9N 20-020-01)

The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.

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 30 days 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.

What The Comprehensive Dental Plan Does Not Cover (GR-9N-28-025-01)

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. 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 dental exclusions are in addition to the exclusions listed under your medical coverage.

Any instruction for diet, plaque control and oral hygiene.

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 Plan Covers* section. Facings on molar crowns and pontics will always be considered **cosmetic**.

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 implants, braces, 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; or
- Under any other plan of group benefits provided by the policyholder.

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, or erosion.

Except as covered in the *What the Plan Covers* section, 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.

First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.

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

Orthodontic treatment except as covered in the *What the Plan Covers* section.

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

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.

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.

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; and
- Cleaning of teeth.

Comprehensive Hearing Expense Insurance Plan

What the Plan Covers

The comprehensive hearing expense insurance plan covers certain hearing care expenses as shown below. Payment for these covered hearing expenses will be payable at the **Coinsurance** and Maximum Benefit per Benefit Period as shown in the Schedule of Benefits. A Benefit Period is a period of three consecutive calendar years, consisting of the current calendar year and the two immediately preceding calendar years.

Hearing Exams

Covered hearing care expenses include charges for an audiometric exam. The services must be performed by:

- a **physician** certified as an otolaryngologist or otologist; or
- an audiologist who either:
 - is legally qualified in audiology; or
 - holds a certificate of Clinical Competence in audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements; and
 - who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam.

Benefits are payable for one hearing aid for each ear and also includes:

- Ear molds;
- Initial batteries; cords and other necessary supplementary equipment;
- Warranty;
- Follow-up consultation within 30 days following the delivery of the hearing aid(s); and
- Repairs, servicing or alteration of the hearing aid equipment;

Exclusions

Not every hearing care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. The plan covers only those services and supplies described above that are **medically necessary**. Charges made for the following are not covered. In addition, some services are specifically limited or excluded.

This section describes expenses that are not covered or subject to special limitations.

- Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet-Certificate.
- **Prescription** or over-the-counter drugs or medicines.
- Hearing care services or supplies which are covered expenses, in whole or in part, under any other plan of group benefits provided through your Employer.
- Hearing care services or supplies which are for which a benefit is provided in whole or in part under any workers' compensation law or any other law of like purpose.
- Any hearing care service or supply which does not meet professionally accepted standards.
- Any hearing care that is experimental in nature.
- Any exams given during a **stay** in a **hospital** or other facility for medical care.
- Medical or surgical treatment of the ears.
- Replacement of a hearing aid that is lost, stolen or broken.

- Replacement of a hearing aid for any reason more than once in a period of 3 consecutive calendar years.
- Hearing services and supplies received while the person is not covered.
- Hearing aids furnished or ordered because of a hearing exam that was done before the date the person becomes covered.
- Hearing exams which:
 - are required by an employer as a condition of employment; or
 - an employer is required to provide under a labor agreement; or
 - are required by any law of a government.
- Batteries and other necessary supplementary equipment other than those obtained with the purchase of the hearing aid.
- A hearing aid exceeding the specifications prescribed for correction of hearing loss.

Benefits After Termination of Coverage

This section applies to a person who is not **totally disabled** on the date coverage under this plan ends.

Expenses incurred for hearing aids within 90 days following the date the person's coverage ends under plan will be deemed to be covered hearing care expenses if:

- the **prescription** for the hearing aid was written; and
- the hearing aid was ordered;
- before the date this coverage ended.

When Coverage Ends (GR-9N-30-005-05 AK)

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. In this case, coverage ends at the end of the calendar month in which you are no longer eligible;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or
- 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 30 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 (GR-9N-30-010-01)

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 (GR-9N-30-015-02)

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 (This does not apply if you use up your lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. 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 (GR-9N-31-010-03)

Continuing Health Care Benefits (GR-9N-31-015-06)

Continuing Coverage for Dependent Students on Medical Leave of Absence (GR-9N-31-015-01)

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 (GR-9N-31-015-01)

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 (GR-9N 31-020 01)

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses incurred in connection with the **injury** or **illness** that caused the total disability will be extended as described below. 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.

Medical Benefits: Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for a period equal to the number of months you have been covered under the Plan when coverage ends, not to exceed 12 months.

When Extension of Benefits End

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.
- Your Lifetime Maximum Benefit, if any, is reached.

(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.

Conversion from a Group to an Individual Plan

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional conversion information, contact your employer or call the toll-free number on your member ID card.

Converting to an Individual Medical Insurance Policy (GR-9N 31-040 01-AK)

Eligibility

If the state where you legally reside requires that an individual health insurance policy be offered when you are no longer covered for medical coverage, regardless of where the group policy may be issued, you and your covered dependents may apply for an individual health insurance policy if you lose coverage under the group health plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

Features of the Conversion Policy

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent's states of residence; and
- Offered by Aetna when you or your dependents apply under your employer's conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less, and there is an applicable overall lifetime maximum benefit.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

Limitations

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are covered under Medicare (Title XVII of the Social Security Act, as amended).
- Coverage under the plan has been in effect for less than three months.
- A lifetime maximum benefit under this plan has been reached. For example:
 - If a covered dependent reaches the group plan’s lifetime maximum benefit, the covered dependent will not have the right to convert. If you or your dependents have remaining benefits, you are eligible to convert.
 - If you have reached your lifetime maximum, you will not be able to convert. However, if a dependent has a remaining benefit, he or she is eligible to convert.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
 - Any other hospital or surgical expense insurance policy;
 - Any hospital service or medical expense indemnity corporation subscriber contract;
 - Any other group contract; or
 - Any statute, welfare plan or program.

Electing an Individual Conversion Policy

You or your covered dependents have to apply for the individual policy within 31 days after your coverage ends. You do not need to provide proof of good health if you apply within the 31 day period.

If coverage ends because of retirement, the 31 day application period begins on the date coverage under the group plan actually ends. This applies even if you or your dependents are eligible for benefits based on a disability continuation provision because you or they are totally disabled.

To apply for an individual medical insurance policy:

- Get a copy of the “Notice of Conversion Privilege and Request” form from your employer.
- Complete and send the form to **Aetna** at the specified address.

Your Premiums and Payments

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna’s** normal rate for the policy that is approved for issuance in your or your dependent’s state of residence.

When an Individual Policy Becomes Effective

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

Coordination of Benefits - What Happens When There is More Than One Health Plan

(GR-9N-33-005-02)

When Coordination of Benefits
Applies

Getting Started - Important Terms

Which Plan Pays First

How Coordination of Benefits Works

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 Plans 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;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- 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 (GR-9N-33-010-01)

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 **noncustodial parent**; and then
 - The plan of the spouse of the **noncustodial 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 Works

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 within 180 days following the date of the payment. 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

(GR-9N-33-020-01)

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:
 1. Refused it;
 2. Dropped it; or
 3. 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 *(GR-9N-33-025-01)*

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 (GR-9N-32-005-02)

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 (GR-9N-32-005-03-AK)

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 (GR-9N-32-005-01-AK)

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 (GR-9N-32-005-01-AK)

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 Policyholder.
- 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 Policyholder or **Aetna**.
- Your Policyholder 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 (GR-9N-32-005-01-AK)

An assignment is the transfer of your rights under the group policy to a person you name.

All coverage may be assigned as long as you provide written notice to **Aetna**.

Misstatements (GR-9N-32-005-03-AK)

If any fact as to the Policyholder 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 Policyholder 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 (GR-9N-32-005-03-AK)

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder 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 Policyholder 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 (GR-9N-32-005-03-AK)

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 that is either fraudulent or material to the risk assumed under this plan.

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 health care coverage, including **prescription drugs**, dental, vision or hearing coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

Subrogation and Right of Reimbursement

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 this plan pays benefits under this Booklet-Certificate to you for expenses incurred due to **Third Party Injuries**, then **Aetna** retains the right to repayment of the full cost of all benefits provided by this plan on your behalf that are associated with the **Third Party Injuries**. **Aetna**’s rights of recovery apply to any recoveries made by or on your behalf from the following sources, including but not limited to:

- Payments made by a **Third Party** or any insurance company on behalf of the **Third Party**;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers’ Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners’ medical payments coverage or premises or homeowners’ insurance coverage; and
- Any other payments from a source intended to compensate you for **injuries** resulting from an accident or alleged negligence.

By accepting benefits under this plan, you specifically acknowledge **Aetna**’s right of subrogation. When this plan pays health care benefits for expenses incurred due to **Third Party Injuries**, **Aetna** shall be subrogated to your right of recovery against any party to the extent of the full cost of all benefits provided by this plan. **Aetna** may proceed against any party with or without your consent.

By accepting benefits under this plan, you also specifically acknowledge **Aetna**’s right of reimbursement. This right of reimbursement attaches when this plan has paid benefits due to **Third Party Injuries** and you or your representative has recovered any amounts from a **Third Party**. By providing any benefit under this Booklet-Certificate, **Aetna** is granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by this plan. **Aetna**’s right of reimbursement is cumulative with and not exclusive of **Aetna**’s subrogation right and **Aetna** may choose to exercise either or both rights of recovery.

By accepting benefits under this plan, you or your representatives further agree to:

- Notify **Aetna** promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to **Third Party Injuries** sustained by you;
- Cooperate with **Aetna** and do whatever is necessary to secure **Aetna**’s rights of subrogation and reimbursement under this Booklet-Certificate;
- Give **Aetna** a first-priority lien on any recovery, settlement, or judgment or other source of compensation which may be had from any party to the extent of the full cost of all benefits associated with **Third Party Injuries** provided by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement);
- Pay, as the first priority, from any recovery, settlement judgment, or other source of compensation, any and all amounts due **Aetna** as reimbursement for the full cost of all benefits associated with **Third Party Injuries** paid by this plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by **Aetna** in writing; and
- Do nothing to prejudice **Aetna**’s rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by the plan.
- Serve as a constructive trustee for the benefits of this plan over any settlement or recovery funds received as a result of **Third Party Injuries**.

Aetna may recover full cost of all benefits paid by this plan under this Booklet-Certificate without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No court costs or attorney fees may be deducted from **Aetna**'s recovery, and **Aetna** is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue your claim or lawsuit against any **Third Party** without the prior express written consent of **Aetna**. In the event you or you representative fail to cooperate with **Aetna**, you shall be responsible for all benefits paid by this plan in addition to costs and attorney's fees incurred by **Aetna** in obtaining repayment.

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 *Subrogation and Right of Reimbursement* 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 (GR-9N-32-015-01-AK)

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
 -
- within 180 days following the date of overpayment.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

Reporting of Claims (GR-9N-32-020-01-AK) (GR-9N-32-015-01-AK)

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.

If you do not receive your claim forms within 15 days after the date you are certain that your request was received, you can fulfill the proof of loss requirement by mailing written proof of:

- The occurrence of the loss; and
- The nature of the loss; and
- The extent of the loss;

to Aetna at the address indicated on your Identification Card.

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 3 years after the deadline.

Payment of Benefits (GR-9N-32-025-02)

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 30 days of receipt by **Aetna** of the due written proof.

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 **physician** provides care for you or a covered dependent, or care is provided by a **network provider** on referral by your **physician (network services or supplies)**, 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 (GR-9N-32-030-02)

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.

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 Benefits Under Other Plans (GR-9N 32-035-01)

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, the following applies:

- If the HMO Plan provides medical coverage, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.
- If the HMO Plan provides dental coverage, you will be excluded from dental expense coverage on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

Any extension of dental benefits under this plan will not apply on or after the date of a change to an HMO Plan.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Prior Coverage - Transferred Business (GR-9N-32-040-02-AK)

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;

coverage under any Major or Comprehensive Medical Expense Coverage section of 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*.

Discount Programs (GR-9N 32-045-01)

Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives (GR-9N 32-045-01)

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

Appeals Procedure (GR-9N-32-050-01 AK)

Definitions

Adverse Benefit Determination (Decision): A denial; reduction; termination of; or failure to; provide or make payment (in whole or in part) for a service, supply or benefit.

Such **adverse benefit determination** may be based on:

- Your eligibility for coverage.
- 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 or supply is not **medically necessary**.

An **adverse benefit determination** also means the termination of your health care coverage (including **prescription drugs**, dental, vision and hearing claims) back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Appeal: An oral or written request to **Aetna** to reconsider an **adverse benefit determination**.

Complaint: Any oral or 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 State Insurance Commissioner and made up of **physicians** or other health care **providers** who hold the same professional license as the treating provider. 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 including **prescription drugs**, dental, vision and hearing care 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 health care claim (including **prescription drugs**, dental, vision and hearing claims) 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 (including Prescription Drug, Dental, Vision and Hearing 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 than 24 hours after the claim is made.

Pre-Service Claims

Aetna will notify you of a **pre-service** claim decision as soon as possible, but not later than 72 hours after the claim is made.

Post-Service Claims

Aetna will notify you of a **post-service** claim decision within 30 calendar days from the date your claim is received by **Aetna**. Your claim will fall into one of the following categories:

- a. Your claim will be paid within 30 days from the date of **Aetna's** receipt.
- b. Your claim will be denied based upon the specific reasons outlined in a notice.
- c. **Aetna** needs additional information as identified in a notice in order to process your claim. **Aetna** must pay the claim on the later of the following:
 - Within 15 days after receiving the specified information in the notice; or
 - Within 30 days from receiving the claim.

If **Aetna** does not provide you with the notice describe in items (b) and (c) above, the claim is assumed to be a **clean claim** and interest, for those covered expenses only, shall accrue at a rate of 15 percent annually beginning on the day following the day that the notice was due and continues to accrue until the date that the claim is paid.

Aetna will not retroactively deny a claim for certified care or treatment unless it is determined that the certification is based on materially incomplete or inaccurate information provided by the **physician** or other health care professional.

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. A decision will be provided not later than 72 hours 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 medical (including **prescription drugs**, dental, vision and hearing) 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 a **provider** you must call or 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**. This Plan provides for one level of **appeal** depending upon the type of coverage provided under the Plan. As to medical (including **prescription drugs**, dental, vision and hearing) claims only, 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 (including **prescription drugs**, dental, vision and hearing) following the receipt of notice of an **adverse benefit determination** to request your **Appeal**. Your **appeal** may be submitted orally or in writing and must include:

- Your name.
- The Employer's name.
- A copy of **Aetna's** notice of an **adverse benefit determination**.
- 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, or call in your **appeal** to Member Services using the telephone number 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 for a group health claim (including **prescription drugs**, dental, vision and hearing claims) in accordance with the guidelines established by the Federal Department of Health and Human Services.

Group Health Claims (including **prescription drugs**, dental, vision and hearing claims)

A review of an **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 18 calendar days of receipt of the request for an **appeal**.

Exhaustion of Process

You may contact the Alaska Division of Insurance **at any time** during the Appeals process if you have any questions or concerns.

You must, however, exhaust the applicable processes of the Appeal Procedure before you:

- Contact the Alaska Division of Insurance to request an investigation of a **complaint** or **appeal**; or
- File a complaint or **appeal** with the Alaska Department of Insurance; 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 for medical claims (including **prescription drugs**, dental, vision and hearing claims)—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 for your health care claims (including **prescription drugs**, dental, vision and hearing claims), 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^(GR-9N-32-051-01 AK)

You may receive an **adverse benefit determination** or **final adverse benefit determination** for medical claims (including **prescription drug**, dental, vision and hearing).

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 by **Aetna**.
- 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* regarding an **adverse benefit determination** or **final adverse benefit determination** notice to the U.S. Office of Personnel Management. You also must include a copy of the notice and all other pertinent information that supports your request.

The U.S. Office of Personnel Management will contact the ERO that will conduct the review of your claim. The ERO will select one or more independent clinical reviewers who hold the same license as the treating provider. 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 21 working 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.

For more information about the Appeals Procedure or **External Review** processes, call the **Member Services** telephone number shown on your ID card.

Glossary

(GR-9N 34-005 01)

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 (GR-9N-34-005-05)

Accident (GR-9N 34-005 01)

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 (GR-9N-34-010-01)

Behavioral Health Provider/Practitioner

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

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 either an **R.N.** or a 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 **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

C (GR-9N 34-015 02)

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.

Copay or Copayment

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.

Creditable Coverage

A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees’ Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children’s Health Insurance Program (S-Chip).

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 (GR-9N 34-020 01)

Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital or residential treatment facility** does not make a room charge for **day care treatment**. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

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.

legally qualified to furnish dental services or supplies.

Dental Emergency

Any dental condition that:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment in order to stabilize the condition; and
- Is characterized by symptoms such as severe pain and bleeding.

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 policyholder 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.

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 (GR-9N 34-025 02)

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate 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

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough 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 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 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 (GR-9N 34-035 01)

Generic Prescription Drug

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

H (GR-9N 34-040 02)

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.

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**.

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 (GR-9N 34-045 02)

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

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- For a woman *who is under 35 years of age*: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman *who is 35 years of age or older*: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

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 (GR-9N 34-050 01)

Jaw Joint Disorder (GR-9N 34-050 01)

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L (GR-9N 34-055 01)

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).

L.P.N.

A licensed practical or vocational nurse.

M (GR-9N-34-065-03 AK)

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

Your plan has a **maximum out-of-pocket limit**. Your **deductibles, coinsurance, copayments** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you meet the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the calendar year. The **maximum out-of-pocket limit** applies to both network and out-of-network out-of-pocket expenses.

The following expenses do not apply toward your **maximum out-of-pocket limits**:

- Charges over the **recognized charge**,
- Any covered expenses paid by **Aetna** at 50%,
- **Non-covered expenses**, and
- Expenses that are not paid or precert benefit reductions made because a **precertification** is needed for the services or supply was not obtained from **Aetna**.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that 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 be:

- a) In accordance with generally accepted standards of medical or dental 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 mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) 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.

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

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 **psychiatric physician**, a psychologist or a psychiatric social worker.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also 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 (GR-9N 34-070 02)

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 Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

Network Provider

A health care provider or **pharmacy** 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**

Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

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** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by 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 (GR-9N 34-075 01-AK)

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** under your Dental plan:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Orthodontic Treatment (GR-9N 34-075 01-AK)

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.

Other Health Care

A health care service or supply that is neither **network service(s) or supply(ies)** nor **out-of-network service(s) and supply(ies)**. **Other health care** can include care given by a provider who does not fall into any of the categories in your provider **directory** (or in DocFind at **Aetna's** website).

Out-of-Network Service(s) and Supply(ies) (GR-9N 34-075 01-AK)

Health care service or supply that is:

- Furnished by an **out-of network provider**.

Out-of-Network Provider

A health care provider, a **pharmacy** or **dental provider** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies at a **negotiated charge**.

P (GR-9N-34-080-05 AK)

Partial Confinement 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 accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy 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 alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

Precertification or Precertify

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.

Preferred Drug Guide

A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** 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** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

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

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required 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 injectable insulin.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, 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 **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** 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 **psychiatric physician**.

- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

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

R (GR-9N-34-090-01 AK)

Recognized Charge (Medical, Dental and Vision Coverage) (GR-9N-34-090-06 AK)

The recognized charge for a service or supply is equal to or greater than the 90th percentile of the Prevailing Charge Rates for the Geographic Area where the service is furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Recognized Charge (Pharmacy and Hearing coverage) (GR-9N-34-090-06 AK)

The recognized charge for a service or supply is equal to or greater than the 80th percentile of the Prevailing Charge Rates for the Geographic Area where the service is furnished.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- **Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- **Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. **Aetna** updates its systems with these changes within 180 days after receiving them from FAIR Health. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

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:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

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

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 (GR-9N 34-095-05)

Self-injectable Drug(s)

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat 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 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 disorders.
- 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.

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.

Specialist Dentist

Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.

Specialty Care

Health care services or supplies that require the services of a **specialist**.

Specialty Pharmacy Network

A network of pharmacies designated to fill **self-injectable drug prescriptions**.

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:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- 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 (GR-9N 34-100-02)

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**.

U (GR-9N-34-105-01)

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 Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
 - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
 - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
 - Makes charges.
 - Is licensed and certified as required by any state or federal law or regulation.
 - Keeps a medical record on each patient.
 - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
 - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
 - Has a full-time administrator who is a licensed **physician**.
- A **physician's** office, but only one that:
 - Has contracted with **Aetna** to provide urgent care; and
 - Is, with **Aetna's** consent, included in the **directory** as a network **urgent care provider**.

It is not the emergency room or outpatient department of a **hospital**.

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 (GR-9N 34-110 01)

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for:

- treatment of unscheduled;
- non-emergency **illnesses**; and
- **Injuries**; and
- the administration of certain immunizations.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a **hospital**, shall be considered a **Walk-in Clinic**.

Aetna Life Insurance Company

Hartford, Connecticut 06156

Booklet-Certificate Amendment – Comprehensive Medical Expense Policy

Policyholder: State Of Alaska

Policy No.: GP-392675

Effective Date: This Policy Amendment is effective on the later of:

July 1, 2014; or

The date you become covered under the Policy.

The policy noted above has been amended. The following summarizes the changes in the policy and Booklet-Certificate describing the policy terms, is amended accordingly. This amendment is effective on the date shown above.

The **Physicians Services** section of your **Comprehensive Medical Expense Benefits** is amended by the addition of the **Surgical Assistants** and **Co-Surgeons** shown below:

Surgical Assistants

Covered expenses also include charges made by a **physician** for providing technical assistance to an operating **physician** when **medically necessary**. This Plan will pay for these services when they are provided during a **hospital confinement** or on an outpatient basis in a **Surgery Center** for a covered surgery.

Payment for surgical assistants will be made at the percentage of the **Recognized Charge** as follows:

- As to an Assistant Surgeon: 16% of the base fee (**Recognized Charge**) for the surgical CPT Code*.
- Non-Physician Assistant Surgeon (e.g. RNs, Physicians' Assistants, etc.): 12% of the base fee (**Recognized Charge**) for the surgical CPT Code*.

* CPT Codes refer to the numerical coding system, defined in the publication *Current Procedural Terminology*, for medical procedures that allows for comparability in pricing, billing, and utilization review.

This plan does **not** cover routine services given by an intern, resident **physician** who is employed by a **hospital** to provide service to patients during the period the intern or resident is receiving training in a medical specialty.

Co-Surgeons

There are also certain surgeries performed that require two or more surgeons. Co-Surgeons must have fulfilled the requirements of the American College of Surgeons and the surgery must be **medically necessary**. Each may perform parts of a single procedure or they may be operating simultaneously (e.g. heart transplant, bilateral orthopedic vascular procedures, etc.).

A co-surgeon may **not** perform the duties of a surgical assistant.

Payment for co-surgeons will be made at the percentage of the **Recognized Charge** as follows:

- 62.5% for base primary procedure fee.
- 31.25% if there is a secondary procedure performed during the surgery.
- 15.625% if there is a third procedure performed during the surgery.

This amendment makes no other changes to the Policy.



Mark T. Bertolini
Chairman, Chief Executive Officer, and President]

Aetna Life Insurance Company
(A Stock Company)

Amendment: Assistant Surgeons - Comprehensive Medical
Issue Date: July 3, 2014

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.

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 INFORMATION

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

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

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

1. An annual routine physical exam for covered persons through age 21.
2. For covered females:
 - Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services, such as:
 - Interpersonal and domestic violence;
 - Sexually transmitted diseases; and
 - Human Immune Deficiency Virus (HIV) infections.
 - Screening for gestational diabetes.
 - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once - three years.
 - A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.
3. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
 - Preventive counseling visits and/or risk factor reduction intervention;
 - Medical nutrition therapy;
 - Nutritional counseling; and
 - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits under your plan may be subject to visit maximums.

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

Benefits under your plan may be subject to visit maximums.

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

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).
7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

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

Benefits under your plan may be subject to maximums.

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health 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.

IMPORTANT HEALTH CARE REFORM INFORMATION

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

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

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

1. Subject to any allowed applicable age, family history and frequency guidelines for preventive services covered under the plan, (which may be in-network only for plans that use a provider network) the following services are included in those considered preventive:
 - Coverage of comprehensive lactation support and counseling, and the costs of renting or purchasing breastfeeding equipment extended for the duration of breastfeeding.
 - In accordance with the recommendations of the United States Preventive Services Task Force, and when prescribed by a physician:
 - i. aspirin for men and women age 45 and over;
 - ii. folic acid for women planning or capable of pregnancy;
 - iii. routine iron supplementation for asymptomatic children ages 6 to 12 months;
 - iv. vitamin D supplementation for men and women age 65 and older;
 - v. fluoride supplementation for children from age 6 months through age 5;
 - vi. genetic counseling, evaluation and lab tests for routine breast cancer susceptibility gene (BRCA) testing;

- vii. Food and Drug Administration (FDA) approved female over-the-counter contraceptives, and an office visit for contraceptive administration and/or removal of a contraceptive device
- 2. The medical in-network out-of-pocket maximum for a plan that does use a provider network , and the out-of-pocket maximums for a plan that does not use a provider network - cannot exceed \$6,350 per person and \$12,700 per family for your 2014 plan year. If your medical plan is packaged with a plan that covers outpatient prescription drugs, the outpatient prescription drug plan may:
 - a. not include out-of-pocket maximums; or
 - b. have separate maximums from the medical plan up to these same amounts; or
 - c. have maximums that are combined with the medical plan up to these same amounts.
- 3. Any annual or lifetime dollar maximum benefit that applies to "Essential Health Benefits" (as defined by the ACA and included in the plan) no longer applies. Essential Health Benefits will continue to be subject to any coinsurance, copays, deductibles, other types of maximums (e.g., day and visit maximums), referral and certification rules, and any exclusions and limitations that apply to these types of covered medical expenses under your plan.
- 4. If your Plan includes a pre-existing condition limitation or exclusion provision, including one that may apply to transplant coverage, then this limitation or exclusion no longer applies.
- 5. If your Plan includes a waiting or probationary period, (the period of time that must pass before your coverage can become effective), this period of time cannot be greater than 90 days.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

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.

Special Medical Travel Reimbursement Program*

***This Program is not an insured benefit under your health plan. It may, however, be used in connection with medically necessary travel expenses per the guidelines set forth below.**

The health plan travel reimbursement program for the State of Alaska Political Subdivisions knows the unique issues of our Alaska members. Below are details on the Special Medical Travel Reimbursement Program and instructions on how to utilize the services.

Before considering utilizing this service, please be aware that:

1. Airfare is not prepaid nor is it guaranteed. You will need to pay for the airfare up front. The program will pay for airfare if corrective surgery or healing treatment is received, which is not available locally. See “Special Medical Travel Reimbursement Program Coverage Details” section below for more information.
2. The program does not reimburse mileage award/frequent flier coupons. The program will only reimburse for dollars the member has spent to acquire travel.

Special Medical Travel Reimbursement Program Coverage Details

The Special Medical Travel Reimbursement Program covers the following:

- Airfare costs within the contiguous United States and the State of Alaska. This includes:
 - Round-trip transportation, but not more than the cost of coach class commercial air transportation, from the place where the illness or injury occurred to the nearest place where professional treatment can be obtained. Only eligible persons are refunded.
 - If the patient is a child under 18 years of age, the plan covers the transportation charges of a parent or legal guardian. Travel charges for a physician or a registered nurse may be covered if pre-approved.
- Transportation will be covered only if:
 - An emergency condition exists requiring immediate transfer to a hospital with special facilities for treating that condition— or —
 - A condition exists that cannot be treated locally. In that case, transportation coverage in any one calendar year will be limited to: one visit and one follow-up visit for a condition requiring therapeutic treatment; one visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery; one pre-surgical or postsurgical visit and one visit for the surgical procedure; and one visit for each allergic condition.
- Transportation charges are not covered for visits for diagnostic purposes. For greater details on exclusions, please contact Aetna Member Services at the number located on your ID card.
- Travel does not include the cost of food, or local ground transportation such as airport shuttles, cabs, or car rental.
- Travel coverage applies only to the conditions covered under the Aetna Medical Plan.

Special Medical Travel Reimbursement Program Enhancements Effective July 1, 2014

For inpatient surgeries where the medical care is received in Seattle and the member uses network providers (facility and professional), the following expenses will also be covered:

- Airfare will be reimbursed for a companion
- Lodging payment of \$50 per night (\$100 if traveling with a companion) beginning one night before the admission, and ending two days following discharge from the hospital.

For outpatient cardiac diagnostic care or treatment where the medical care is received in Seattle and at a facility contracted with Aetna as an Institute of Quality (IOQ), the following expense will also be covered:

- Lodging payment of \$50 per night for up to a maximum of two nights.

The travel reimbursement program for when medical care is received in Seattle as outlined above will be allowed whether or not the care could be provided locally in Alaska.

How to File for Reimbursement

To apply for reimbursement, the following information will be needed:

- If flying, a copy of your boarding pass or airline tickets. Reservation printouts cannot be accepted. (*Destination, origination, date of travel, passenger's name and price paid for the ticket must be present on the documentation*).
- A completed Medical Reimbursement Request Claim Form. You can download the form from your secure Aetna Navigator® website at www.aetna.com.

Fax the claim form and other information to 1-859-455-8650
or mail to –
Aetna Claims
P.O. Box 14079
Lexington, KY 40512-4079

Processing the reimbursement will take between 17-24 days after receipt of all information outlined above.