BENEFIT PLAN

Prepared Exclusively For
SAMPLE

Open Access Managed Choice

Aetna Life Insurance Company
Booklet-Certificate

What Your Plan Covers and How Benefits are Paid

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

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

Employer: SAMPLE
Group Policy Number: GP-920282
Issue Date: SAMPLE
Effective Date: 00/00/00
Schedule: 00/00/00
Cert Base: 3

For: Open Access Managed Choice

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Gatekeeper PPO Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible*</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family Deductible*</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan deductible and copayments.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:

- For network expenses: $1,000.
- For out-of-network expenses: $2,000.

Family Maximum Out of Pocket Limit:

- For network expenses: $2,000.
- For out-of-network expenses: $4,000.

Lifetime Maximum Benefit per person

Unlimited

Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.
All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physical Exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>100% per visit</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Preventive Care Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or</td>
<td>100% per visit</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>physician's office</td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subject to any age limits provided for in</td>
<td>Subject to any age limits provided for in</td>
</tr>
<tr>
<td></td>
<td>the comprehensive guidelines supported by</td>
<td>the comprehensive guidelines supported by</td>
</tr>
<tr>
<td></td>
<td>the Health Resources and Services</td>
<td>the Health Resources and Services</td>
</tr>
<tr>
<td></td>
<td>Administration.</td>
<td>Administration.</td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician, log</td>
<td>For details, contact your physician, log</td>
</tr>
<tr>
<td></td>
<td>onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a> or</td>
<td>onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a> or</td>
</tr>
<tr>
<td></td>
<td>call the number on the back of your ID card.</td>
<td>call the number on the back of your ID card.</td>
</tr>
</tbody>
</table>

Covered Persons through age 21:
Maximum Age & Visit Limits
- Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- For details, contact your physician, log onto the Aetna website www.aetna.com or call the number on the back of your ID card.

Covered Persons age 65 and over:
Maximum Visits per 12 consecutive months
- Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- For details, contact your physician, log onto the Aetna website www.aetna.com or call the number on the back of your ID card.
### Screening & Counseling Services

**Office Visit**

- Obesity,
- Misuse of Alcohol and/or Drugs
- Use of Tobacco Products

100% per visits

No copay or deductible applies.

70% per visits after Calendar Year deductible

<table>
<thead>
<tr>
<th>Obesity (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per 12 consecutive months</td>
</tr>
<tr>
<td>(This maximum applies only to Covered Persons ages 22 &amp; older.)</td>
</tr>
<tr>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease) *</td>
</tr>
<tr>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease) *</td>
</tr>
</tbody>
</table>

*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

<table>
<thead>
<tr>
<th>Misuse of Alcohol and/or Drugs (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per 12 consecutive months</td>
</tr>
<tr>
<td>5 visits *</td>
</tr>
</tbody>
</table>

*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

<table>
<thead>
<tr>
<th>Use of Tobacco Products (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per 12 consecutive months</td>
</tr>
<tr>
<td>8 visits *</td>
</tr>
</tbody>
</table>

*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.

<table>
<thead>
<tr>
<th>Well Woman Preventive Visits (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
</tr>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No copay or Calendar Year deductible applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Woman Preventive Visits (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per Calendar Year</td>
</tr>
<tr>
<td>1 visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine Cancer Screening Outpatient (GR-9N S 10-016 03 NG CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No Calendar Year deductible applies.</td>
</tr>
</tbody>
</table>

70% per visit after Calendar Year deductible.
Subject to any age; family history; and frequency guidelines as set forth in the most current:

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

For details, contact your physician, log onto the Aetna website [www.aetna.com](http://www.aetna.com), or call the number on the back of your ID card.

### Prenatal Care Office Visits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

**Important Note**: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

### Comprehensive Lactation Support and Counseling Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per item.</td>
<td>70% per item after Calendar Year deductible</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

**Important Note**: Refer to the Comprehensive Lactation Support and Counseling Services section of the Booklet for limitations on breast pumps and supplies.

### Family Planning Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit.</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>
Contraceptive Counseling Services -
Maximum Visits per 12 months
either in a group or individual
setting

2* visits
2* visits

*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered
under the Physician Services office visit section of the Schedule of Benefits.

<table>
<thead>
<tr>
<th>Family Planning Services - Female Voluntary Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
</tr>
<tr>
<td>100% per admission.</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
</tr>
<tr>
<td>70% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>100% per visit/surgical procedure.</td>
</tr>
<tr>
<td>No copay or deductible applies.</td>
</tr>
<tr>
<td>70% per visit/surgical procedure after Calendar Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>PLAN COINSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning Services - Female Contraceptives</td>
<td></td>
</tr>
<tr>
<td>Female Contraceptive Devices</td>
<td>100% per prescription or refill</td>
</tr>
<tr>
<td></td>
<td>No deductible applies.</td>
</tr>
</tbody>
</table>

Important Note:
Refer to the Outpatient Prescription Drug Expenses section of your Schedule of Benefits for more information on
other prescription drug coverage under this Plan.

<table>
<thead>
<tr>
<th>Family Planning – Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary Termination of Pregnancy</td>
</tr>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>90% per visit/surgical procedure after Calendar Year deductible.</td>
</tr>
<tr>
<td>70% per visit/surgical procedure after Calendar Year deductible.</td>
</tr>
</tbody>
</table>

| Voluntary Sterilization for Males |
| Outpatient                        |
| 90% per visit/surgical procedure after Calendar Year deductible. |
| 70% per visit/surgical procedure after Calendar Year deductible. |

<table>
<thead>
<tr>
<th>Maximum Benefit for Tumors, and Leukemia, Wigs and Breast Prosthesis Services Calendar Year Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Chemotherapy</td>
</tr>
<tr>
<td>$500</td>
</tr>
<tr>
<td>Outpatient Chemotherapy following Surgery</td>
</tr>
<tr>
<td>$500</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
</tr>
<tr>
<td>$500</td>
</tr>
<tr>
<td>Non-Dental Prosthesis</td>
</tr>
<tr>
<td>$300</td>
</tr>
<tr>
<td>Hair Prosthesis</td>
</tr>
<tr>
<td>$350</td>
</tr>
<tr>
<td>Breast Prosthesis</td>
</tr>
<tr>
<td>$300 per breast</td>
</tr>
</tbody>
</table>

$500 $500 $500 $300 $350 $300 per breast
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision Care</strong> (GR-9N S-11-020-01 CT)</td>
<td><strong>Eye Examinations</strong> including refraction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of the <strong>negotiated charge</strong> after a $20 exam</td>
<td>70% per exam after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per 24 consecutive month period</td>
<td>1 exam</td>
<td>1 exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong> (GR-9N S-11-025-03 CT)</td>
<td><strong>Office Visits to Primary Care Physician</strong> Office visits (non-surgical) to non-specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% of the <strong>negotiated charge</strong> after a $20 visit <strong>copay</strong></td>
<td>70% per visit after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year <strong>deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>

| **Alternatives to Physicians' Office Visits** (GR-9N S-10-025 09 CT) | **E-Visit Online or Telephonic Consultation by a PCP** $20 visit **copay** then the plan pays 100% | Not Covered |
|                                                               | No Calendar Year **deductible** applies.                                 |                                                               |

| **Specialist Office Visits (including Mental and Nervous Conditions)** | 100% of the **negotiated charge** after a $20 per visit **copay** | 70% per visit after Calendar Year **deductible** |
|                                                               | No Calendar Year **deductible** applies.                                 |                                                               |

| **Alternative to Specialist Office Visit** (GR-9N S-10-025 09 CT) | **E-visits Online or Telemedicine Consultation by a Specialist** $20 visit **copay** then the plan pays 100% | Not Covered |
|                                                               | No Calendar Year **deductible** applies.                                 |                                                               |

<p>| <strong>Physician Office Visits-Surgery</strong> | 100% of the <strong>negotiated charge</strong> after a $20 visit <strong>copay</strong> | 70% per visit after Calendar Year <strong>deductible</strong> |
|                                                               | No Calendar Year <strong>deductible</strong> applies.                                 |                                                               |</p>
<table>
<thead>
<tr>
<th>Walk-In Clinics Non-Emergency Visit (GR-9N-S-10.25-01 CT)</th>
<th>$20 visit copay then the plan pays 100%</th>
<th>70% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialist Physician Services for Inpatient Facility and Hospital Visits</th>
<th>90% per visit after Calendar Year deductible</th>
<th>70% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration of Anesthesia</td>
<td>90% per procedure after Calendar Year deductible</td>
<td>70% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
</tbody>
</table>

## PLAN FEATURES

### NETWORK

<table>
<thead>
<tr>
<th>Emergency Medical Services (GR-9N-S.11.030.01 CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Emergency Facility and Physician</td>
</tr>
<tr>
<td>100% of the negotiated charge after a $75 per visit copay</td>
</tr>
<tr>
<td>No Calendar Year deductible applies.</td>
</tr>
<tr>
<td>Paid the same as the Network level of benefits.</td>
</tr>
<tr>
<td>See Important Note Below</td>
</tr>
</tbody>
</table>

**Important Note:** Please note that as these providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

<table>
<thead>
<tr>
<th>Non-Emergency Care in a Hospital Emergency Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Important Notice:**

Covered expenses that are applied to the emergency room per visit copay/deductible cannot be applied to any other copay/deductible under your plan. Likewise, covered expenses that are applied to any of your plan's other copays/deductibles cannot be applied to the emergency room copay/deductible.
### Urgent Care Services

<table>
<thead>
<tr>
<th>Urgent Medical Care</th>
<th>100% of the negotiated charge after a $50 per visit copay</th>
<th>70% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>(at a non-hospital free standing facility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Medical Care</th>
<th>Refer to Emergency Medical Services and Physician Services above.</th>
<th>Refer to Emergency Medical Services and Physician Services above.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(from other than a non-hospital free standing facility)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Urgent Use of Urgent Care Provider</th>
<th>Not covered</th>
<th>Not covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>(at an Emergency Room or a non-hospital free standing facility)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Important Notice:
Covered expenses that are applied to the urgent care copay/deductible cannot be applied to any other copay/deductible under your plan. Likewise, covered expenses that are applied to your plan’s other copays/deductibles cannot be applied to the urgent care copay/deductible.

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Outpatient Diagnostic and Preoperative Testing (GR-9N 5-11-035-01 CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Imaging Services</td>
</tr>
<tr>
<td>Complex Imaging</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Diagnostic Laboratory Testing</td>
</tr>
<tr>
<td>Diagnostic Laboratory Testing</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Diagnostic X-Rays (except Complex Imaging Services)</td>
</tr>
<tr>
<td>Diagnostic X-Rays</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Outpatient Surgery (GR-9N 5-11-046-01 CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient Facility Expenses</strong> (GR-9N S-11-045-01 CT)</td>
</tr>
<tr>
<td><strong>Birthing Center</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
</tr>
<tr>
<td>Room and Board (including maternity)</td>
</tr>
<tr>
<td>Other than Room and Board</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Inpatient Facility</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maximum Days per Calendar Year</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Specialty Benefits</strong> (GR-9N S-11-050-01 CT)</td>
</tr>
<tr>
<td><strong>Home Health Care (Outpatient)</strong></td>
</tr>
<tr>
<td>(Maximum <strong>deductible</strong> for HHC will not exceed $50)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maximum Visits per Calendar Year</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Care (Outpatient)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Hospice Benefits</strong></td>
</tr>
<tr>
<td><strong>Hospice Care - Facility Expenses</strong> (Room &amp; Board)</td>
</tr>
<tr>
<td><strong>Hospice Care - Other Expenses during a stay</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per lifetime</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Hospice Outpatient Visits</strong></td>
</tr>
<tr>
<td>PLAN FEATURES</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td><strong>Infertility Treatment (GR-9N-S-11-035-01 CT)</strong></td>
</tr>
<tr>
<td><strong>Infertility Expenses</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Mental Disorders (GR-9N-S-11-062-01 CT)</strong></td>
</tr>
<tr>
<td><strong>MENTAL DISORDERS</strong></td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Residential Treatment Facility Expenses</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Treatment Of Mental Disorders</strong></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>PLAN FEATURES</strong></td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Substance Abuse</strong></td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Residential Treatment Facility Expenses</strong></td>
</tr>
</tbody>
</table>
### Outpatient Treatment of Substance Abuse

**Outpatient Treatment**

$20 per visit **copay** then the plan pays 100% of the Negotiated Charge.

No Calendar Year **deductible** applies

70% per visit after Calendar Year **deductible**

---

### PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>(IOE Facility)</td>
<td>(Non-IOE Facility)</td>
<td></td>
</tr>
</tbody>
</table>

#### Transplant Services Facility and Non-Facility Expenses (GR-9N S-11-075-01 CT)

<table>
<thead>
<tr>
<th>Service</th>
<th>NETWORK</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplant Facility Expenses</strong></td>
<td>90% per admission after Calendar Year <strong>deductible</strong></td>
<td>70% per admission after Calendar Year <strong>deductible</strong></td>
<td>70% per admission after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Transplant Specialist Services</strong> (including office visits)</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided</td>
</tr>
</tbody>
</table>

#### Other Covered Health Expenses (GR-9N-11-080-01 CT)

<table>
<thead>
<tr>
<th>Service</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture in lieu of anesthesia</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>90% after Calendar Year <strong>deductible</strong></td>
<td>70% after Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Durable Medical and Surgical Equipment</strong></td>
<td>90% per item after the Calendar Year <strong>deductible</strong></td>
<td>70% per item after the Calendar Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (Surgery)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (Visit)</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><strong>Orthotic and Prosthetic Devices</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

#### NETWORK

**Outpatient Therapies (GR-9N 5-11-090-01 CT)**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
</tbody>
</table>

#### OUT-OF-NETWORK

**Short Term Outpatient Rehabilitation Therapies (GR-9N 11-095-01 CT)**

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Physical, Occupational and Speech</td>
<td>100% of the negotiated charge after a $20 per visit copay. No Calendar Year deductible.</td>
</tr>
<tr>
<td>Therapy combined</td>
<td>70% per visit after Calendar Year deductible.</td>
</tr>
</tbody>
</table>

**Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year**

- **Network**: 60 visits
- **Out-of-Network**: 60 visits

#### Spinal Manipulation (GR-9N 11-095-01 CT)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal Manipulation</td>
<td>100% of the negotiated charge after a $20 per visit copay. No Calendar Year deductible.</td>
</tr>
<tr>
<td></td>
<td>70% per visit after the Calendar Year deductible.</td>
</tr>
</tbody>
</table>

**Spinal Manipulation Maximum visits per Calendar Year**

- **Network**: 20 visits
- **Out-of-Network**: 20 visits

#### Autism Spectrum Disorder (GR-9N 11-61-02 CT)

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Payable in accordance with the type of expense incurred and the place where service is provided.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Cost sharing is based upon the type of service or supply provided and the place where service is rendered.</td>
</tr>
<tr>
<td></td>
<td>Cost sharing is based upon the type of service or supply provided and the place where service is rendered.</td>
</tr>
</tbody>
</table>

**Maximum benefit per calendar year**
for behavioral therapy

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Benefit Maximum</th>
<th>Benefit Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under age 9:</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Children age 9 but less than 13:</td>
<td>$35,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Children age 13 but less than 15:</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

Once the benefit maximums above have been reached, coverage for behavioral therapy will cease. All other coverage for diagnosis and all other treatment including Applied Behavioral Analysis will continue to be provided on the same basis as for any other illness under this Booklet-Certificate.

**Early Intervention Services**

<table>
<thead>
<tr>
<th>Description</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td>100% per visit</td>
<td></td>
</tr>
<tr>
<td>No copay or Calendar Year deductible applies.</td>
<td>No Calendar Year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit 64 visits combined PT/OT/ST per calendar year not to exceed 192 visits in a three year period</td>
<td>64 visits combined PT/OT/ST per calendar year not to exceed 192 visits in a three year period</td>
<td></td>
</tr>
</tbody>
</table>

Maximum benefit per Calendar Year, for child diagnosed with Autism Spectrum Disorder receiving early intervention services.

<table>
<thead>
<tr>
<th>Description</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000</td>
<td>$50,000</td>
<td></td>
</tr>
</tbody>
</table>

For Three Year Period

<table>
<thead>
<tr>
<th>Description</th>
<th>Outpatient</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150,000</td>
<td>$150,000</td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy Benefit** (GR-9N-S-26-005-01)

**Copays/Deductibles** (GR-9N-S-26-011-01) (GR-9N-S-26-013-01) (GR-9N-S-26-016-01)

<table>
<thead>
<tr>
<th>Preferred Generic Prescription Drugs</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each initial 30 day supply filled at a retail pharmacy</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy</td>
<td>$20</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Preferred Brand-Name Prescription Drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>Retail Pharmacy</th>
<th>Mail Order Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each initial 30 day supply filled at a retail pharmacy</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td>For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy</td>
<td>$50</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

Non-Preferred Brand-Name Prescription Drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>Retail Pharmacy</th>
<th>Mail Order Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each initial 30 day supply filled at a retail pharmacy</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy</td>
<td>$100</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the brand-name prescription drug. If you request a covered brand-name prescription drug where a generic prescription drug equivalent is available you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug equivalent, plus the applicable cost sharing.

Copay and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and any prescription drug Calendar Year deductible will not apply to contraceptive methods that are:
- generic prescription drugs; generic devices; or
- FDA-approved female generic emergency contraceptives, when obtained at a network pharmacy.

This means that such contraceptive methods will be paid at 100%.

With respect to those plans that provide out-of-network pharmacy benefits under the Prescription Drug Plan, the per prescription copay/deductible and any applicable prescription drug Calendar Year deductible continue to apply.

The per prescription copay/deductible and any prescription drug Calendar Year deductible continue to apply:
- For contraceptive methods that are:
  - brand-name prescription drugs and brand name devices and
  - FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent, or generic alternative available within the same therapeutic drug class unless you are granted a medical exception.
Coinsurance

<table>
<thead>
<tr>
<th>Prescription Drug Plan Coinsurance</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of the negotiated charge</td>
<td>70% of the recognized charge</td>
</tr>
</tbody>
</table>

The prescription drug plan coinsurance is the percentage of prescription drug covered expenses that the plan pays after any applicable deductibles and copays have been met.

Expense Provisions (GR-9N S-09-05 01)

The following provisions apply to your health expense plan. This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this Schedule of Benefits.

The insurance described in this Schedule of Benefits will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Deductible Provisions (GR-9N S-09-05 01)

Network Calendar Year Deductible
This is an amount of network covered expenses incurred each Calendar Year for which no benefits will be paid. The network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible
This is an amount of out-of-network covered expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the out-of-network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.

Network Family Deductible Limit
When you incur network covered expenses that apply toward the network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the network Calendar Year family deductible limit. Your network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the network family deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit
When you incur out-of-network covered expenses that apply toward the out-of-network Calendar Year deductibles for you and each of your covered dependents these expenses will also count toward the out-of-network Calendar Year family deductible limit. Your out-of-network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the out-of-network family deductible limit in a Calendar Year.

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.
Copayments and Benefit Deductible Provisions (GR-9N-09-015-01 CT)

Copayment, Copay
This is a specified dollar amount or percentage of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

Coinsurance Provisions (GR-9N-S-09-020-01)

Coinsurance
This is the percentage of your 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 the “Plan Coinsurance”. Once applicable deductibles have been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The coinsurance percentage may vary by the type of expense. Refer to your Schedule of Benefits for coinsurance amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for covered expenses during the Calendar Year. Once you satisfy the 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. The Maximum Out-of-Pocket Limit applies to both network and out-of-network benefits.

This plan has an Individual Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for that person.

There is also a Family Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for all covered family members.

The Maximum Out-of-Pocket Limit applies to both network and out-of-network benefits. Covered expenses applied to the out-of-network Maximum Out-of-Pocket Limit will be applied to satisfy the in-network Maximum Out-of-Pocket Limit and covered expenses applied to the in-network Maximum Out-of-Pocket Limit will be applied to satisfy the out-of-network Maximum Out-of-Pocket Limit.

Covered expenses that are subject to the Maximum Out-of-Pocket Limit include prescription drug expenses provided under the Medical or Prescription drug Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan out-of-pocket limit. These include:

- Charges over the recognized charge;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an urgent care provider; and
- Expenses that are not paid, or precertification benefit reductions because a required precertification for the service(s) or supply was not obtained from Aetna.
Precertification Benefit Reduction (GR-9N 5-09-01)

The Booklet-Certificate contains a complete description of the precertification program. Refer to the “Understanding Precertification” section for a list of services and supplies that require precertification.

Failure to precertify your covered expenses when required will result in a benefits reduction as follows:

- A $400 benefit reduction will be applied separately to each type of expense.

General (GR-9N 5-28-01)

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.
Preface (GR-9N-02-005-01 CT)

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: SAMPLE
Group Policy Number: GP-920282
Effective Date: 00/00/00
Issue Date: 00/00/00
Booklet-Certificate Number: 3

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-CT)
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 CT)
Health Expense Coverage (GR-9N-02-020-01 CT)
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 CT)
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.
Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

Who Can Be Covered

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

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

Determining if You Are in an Eligible Class
You are in an eligible class if:

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

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
If you are hired after the effective date of this plan, your coverage eligibility date is the date you are hired.

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

Obtaining Coverage for Dependents
Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; and
- Your dependent children.

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

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

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

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

**Important Reminder**

Keep in mind that you cannot receive coverage under the plan as:

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

**How and When to Enroll**

**Initial Enrollment in the Plan**

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions 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. 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.

Newborns are automatically covered for 61 days after birth. To continue coverage after 61 days, you will need to complete a change form and return it to your employer within the 61-day enrollment period.

**Late Enrollment**

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

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

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

**Annual Enrollment**

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. The choices you make during this annual enrollment period will become effective the following year.
If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

**Special Enrollment Periods (GR-9N-29-015-05)**

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 your employment;
  - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan’s coverage;
  - 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 you belong;
  - Cessation of a dependent’s status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached the lifetime maximum of another Plan for all benefits under that Plan.
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

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

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

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

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

- The child meets the plan’s definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to Aetna prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage;

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

- The child meets the plan’s definition of an eligible dependent; and
- You request coverage for the child in writing within 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

Your Effective Date of Coverage
Your coverage takes effect on the later of:

- The date you are eligible for coverage; or
- The date your enrollment information is received.

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

Your Dependent’s Effective Date of Coverage
Your dependent’s coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan by then.

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 Enrollment Periods section will apply.
How Your Medical Plan Works

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

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

Important Notes

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

Common Terms

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

About Your Gatekeeper PPO Medical Plan

This Preferred Provider Organization Gatekeeper (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 Gatekeeper PPO plan, you can directly access any physician, hospital or other health care provider (network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through network providers or out-of-network providers.

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

This Gatekeeper PPO plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This Gatekeeper
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.

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

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

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

Ongoing Reviews
Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If Aetna determines that the recommended services or supplies are not covered 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 Gatekeeper PPO plan, please carefully review the following information.

How Your Gatekeeper PPO Medical Plan Works

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

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

A PCP may be a general practitioner, family physician, internist, or pediatrician. Your PCP provides routine preventive care and will treat you for illness or injury.

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

Changing Your PCP
You may change your PCP at any time on Aetna’s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon Aetna’s receipt and approval of the request.
Specialists and Other Network Providers
You may directly access specialists and other health care professionals in the network for covered services and supplies under this Booklet-Certificate. Refer to the Aetna provider directory to locate network specialists, providers and hospitals in your area. Refer to the Schedule of Benefits section for benefit limitations and out-of-pocket costs applicable to your plan.

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

Accessing Network Providers and Benefits
You may select a PCP or other direct access network provider from the network provider directory or by logging on to Aetna’s website at www.aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of physicians and other health care providers and facilities. You can change your PCP at any time.

If a service you need is covered under the plan but not available from a network provider or hospital in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.

Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification with Aetna to verify coverage for these services. You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a network provider’s failure 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.

You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your network provider will take care of claim submission. Aetna will directly pay the network provider or facility less any cost sharing required by you. You will be responsible for deductibles, coinsurance and copayments, if any.

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

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

Network providers have agreed to accept the negotiated charge. Aetna will reimburse you for a covered expense, incurred from a network provider, up to the negotiated charge and the maximum benefits under this Plan, less any cost sharing required by you such as deductibles, copayments and payment percentage. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply.

You must satisfy any applicable deductibles before the plan will begin to pay benefits.

Deductibles and payment percentage are usually lower when you use network providers than when you use out-of-network providers.

For certain types of services and supplies, you will be responsible for any copayments shown in the Schedule of Benefits.

After you satisfy any applicable deductible, you will be responsible for any applicable 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 the Schedule of Benefits section for information on what expenses do not apply. Refer to your **Schedule of Benefits** for the specific **maximum out-of-pocket limit** amounts 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, copayment, or coinsurance** amounts, or any non-covered expenses that you incur.

**Accessing Out-of-Network Providers and Benefits** *(GR-9N 08-045-01-CT)*

You have the choice to directly access physicians, hospitals or other health care providers in-network without a referral. You will still be covered when you access providers for covered benefits without a referral from your PCP. Benefits will be calculated as out-of-network. When your medical service is provided out-of-network, the level of reimbursement from the plan for covered expenses will usually be lower. This means your out-of-pocket expenses will generally be higher.

You have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Your out-of-pocket costs, such as deductibles 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. Aetna will only pay up to the recognized charge.

- You select a health care provider or facility for covered benefits.
- **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 will be reduced by $500 or 50% of the cost of the expense whichever is less, or the expense may not be covered if the service or supply is not medically necessary. 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 full 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 of you by your plan.
- If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe towards 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 of this Booklet-Certificate for information on how to precertify.

**Cost Sharing for Out-of-Network Benefits** *(GR-9N 08-045-01)*

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.
Out-of-network providers have not agreed to accept the negotiated charge. Aetna will reimburse you for a covered expense, incurred from an out-of-network provider, up to the recognized charge and the maximum benefits under this Plan, less any cost-sharing required by you such as deductibles and payment percentage. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider. Your payment percentage is based on the recognized charge. If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. Except for emergency services, Aetna will only pay up to the recognized charge.

You must satisfy any applicable deductibles before the plan begins to pay benefits.

Deductibles and payment percentage are usually higher when you use out-of-network providers than when you use network providers.

After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance for covered expenses that you incur. You will be responsible for your coinsurance up to the maximum out-of-pocket limit applicable to your plan.

Your coinsurance will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge.

Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to your Schedule of Benefits for specific dollar amounts.

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.

Understanding Precertification (GR-9N 08-060-01-CT)

Precertification

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

You do not need to precertify services 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 or supplies on the precertification list below. If you do not precertify, your benefits will be reduced by $500 or 50% of the cost of the expense whichever is less, or the plan may not pay any of the expenses if the service or supply is not medically necessary. 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 or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

You are responsible for obtaining precertification. You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification pursuant to this Booklet-Certificate in accordance with the following timelines:
Precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

<table>
<thead>
<tr>
<th>For non-emergency admissions:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For an emergency outpatient medical condition:</td>
<td>You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.</td>
</tr>
<tr>
<td>For an emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission:</td>
<td>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.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
<tr>
<td>For prenatal care and delivery:</td>
<td>As soon as possible after the attending physician confirms pregnancy and again within 48 hours of the birth or as soon thereafter as possible. No benefit reduction will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.</td>
</tr>
</tbody>
</table>

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

Services and Supplies Which Require Precertification (GR-9N 08-065-04)
Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse;
- Partial Hospitalization Programs for mental disorders and substance abuse;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing.

**How Failure to Precertify Affects Your Benefits (GR-9N 08.070.01-CT)**

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. If your treatment is not precertified by you or your provider, the benefit payable will be reduced by $500 or 50% of the expense whichever is less, or your expenses may not be covered if the service or supply is not medically necessary.

**How Your Benefits are Affected**
The chart below illustrates the effect on your benefits if necessary precertification is not obtained.

<table>
<thead>
<tr>
<th>If precertification is:</th>
<th>then the expenses are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ requested and approved by Aetna</td>
<td>▪ covered</td>
</tr>
<tr>
<td>▪ requested and denied.</td>
<td>▪ not covered, may be appealed.</td>
</tr>
<tr>
<td>▪ not requested, but would have been covered if requested.</td>
<td>▪ covered after a precertification benefit reduction is applied.*</td>
</tr>
<tr>
<td>▪ not requested, would not have been covered if requested.</td>
<td>▪ not covered, may be appealed.</td>
</tr>
</tbody>
</table>

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.

**Emergency and Urgent Care (GR-9N-27-005-01)**

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

- An emergency medical condition; or
- An urgent condition.
In Case of a Medical Emergency
When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your primary care physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your PCP to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the Schedule of Benefits for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

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

In Case of an Urgent Condition (GR-9N-27-010-01)

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

If it is not feasible to contact your PCP, 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.

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

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

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician 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 expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your Schedule of Benefits for cost sharing information applicable to your plan.
To keep your out-of-pocket costs lower, your follow-up care should be accessed through your PCP.

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

Important Notice
Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should not be provided by an emergency room facility.
Requirements for Coverage  (GR-9N-09-005-01 CT)

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 services, supply or prescription drug must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
   (a) In accordance with generally accepted standards of medical practice;
   (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
   (c) Not primarily for the convenience of the patient, physician or other health care provider;
   (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

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

Important Note
Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical 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

Gatekeeper PPO Medical Plan

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

Preventive Care

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 primary care physician (PCP) for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
- Interpersonal and domestic violence;
- Sexually transmitted diseases; and
- Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.

- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial hospital checkup.

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

Routine Cancer Screenings
Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:
- Mammograms, including baseline for women 35 to 39, yearly for women age 40 and over (including ultrasound);
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

These benefits will be subject to any age, family history, and frequency guidelines that are:
- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers one baseline mammogram for a woman age 35 but less than age 40.

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

Important Notes:
1. Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your physician, log onto the Aetna website www.aetna.com, or call Member Services at the number on the back of your ID card.
Preventive Care Immunizations (GR-9N 11-006 02 NG CT)

Covered expenses include charges made by your primary care physician (PCP) or a facility for:
- immunizations for infectious diseases; and
- the materials for administration of immunizations;

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

Limitations
Not covered under this Preventive Care benefit are charges incurred for:
- Services which are covered to any extent under any other part of this Plan;
- Immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits (GR-9N 11-006 02 NG CT)

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

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

Screening and Counseling Services (GR-9N 11-006 02 NG CT)

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

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

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

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

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits.
Use of Tobacco Products
Screening and counseling services to aid you to stop the use of tobacco products.

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

to aid you to stop the use of tobacco products.

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

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

Limitations
Unless specified above, not covered under this benefit are charges for:
- Services which are covered to any extent under any other part of this Plan.

Prenatal Care

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

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

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

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

Comprehensive Lactation Support and Counseling Services
Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post partum period by a certified lactation support provider. The "post partum period" means the one year period directly following the child's date of birth. Covered expenses incurred during the post partum period also include the rental or purchase of breast feeding equipment as described below.
Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your Schedule of Benefits.

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

**Breast Pump**
**Covered expenses** include the following:
- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered for each pregnancy; or
  - A manual breast pump. A purchase will be covered for each pregnancy.
- If an electric breast pump or manual pump is purchased during a pregnancy, the purchase of another electric or manual pump will **not** be covered for that same pregnancy.

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

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

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

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

**Important Notes:**
If a breast pump service or supply that you need is covered under this Plan but not available from a **network provider** in your area, please contact Member Services at the toll-free number on your ID card for assistance.

**Family Planning Services – Female Contraceptives** *(GR-9N 11-006 02 NG CT)*
For females with reproductive capacity, **covered expenses** include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

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

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

**Voluntary Sterilization**
**Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.
Covered expenses under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

Contraceptives
 Covered expenses include charges made by a physician for:
- Female contraceptive devices including the related services and supplies needed to administer the device.

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

Family Planning Services – Other
Covered expenses include charges for certain family planning services even though not provided to treat an illness or injury.
- Voluntary sterilization for males
- Voluntary termination of pregnancy

Limitations
Not covered are:
- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

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

Blood Lead Screening and Risk Assessments
This plan pays for the charges made by physician for blood lead screening and risk assessment when ordered by your physician, subject to the following:

Coverage is included for:
- annual screening for children 9-35 months of age;
- screening for children 36-72 months who have not previously been screened or for any child under 72 months of age, if clinically indicated as determined by their Physician;
- annual assessment for children 36-72 months of age; and
- assessment for children 36 months of age or younger, if determined that assessment is needed.
Vision Care Services  
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 24 consecutive month period.

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

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

- 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  
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.

E-Visits
Covered expenses include charges made by your network primary care physician (PCP) for a routine, non-emergency, medical consultation. You must make your E-visit through an Aetna authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.Aetna.com or by calling the number on your identification card.
Hospital Expenses *(GR 9N S 11-030 CT)*

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.

**Dental Anesthesia**  
**Covered expenses** also include expenses for general anesthesia, nursing and related hospital services provided in conjunction with inpatient dental services when the following conditions are met:

- the anesthesia, nursing and related hospital services are deemed necessary by the treating dentist or oral surgeon; and
- you:
  - (a) are determined by a licensed dentist in conjunction with a physician, who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or
  - (b) have a developmental disability, as determined by a physician, that places you at serious risk.

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

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

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

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

Covered expenses also include expenses for general anesthesia, nursing and related Hospital services provided in conjunction with outpatient or one day dental services when the following conditions are met:

- the anesthesia, nursing and related hospital services are deemed necessary by the treating dentist or oral surgeon; and
- you:
  - are determined by a licensed dentist in conjunction with a physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or
  - have a developmental disability, as determined by a physician, that places the you at serious risk.

Important Reminders

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

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

Hospital admissions need to be precertified by Aetna. Refer to How 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. Covered expenses for these charges are payable at the out-of-network benefit level if the provider has not contracted with Aetna, even if the facility is in the Aetna network.

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

Coverage for Emergency Medical Conditions (GR-9N S-11-035-01 CT)

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 PCP after receiving treatment for an emergency medical condition.

Important Reminder

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

Coverage for Urgent Conditions (GR-9N S-11-035-01 CT)

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 PCP after receiving treatment of an urgent condition.

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

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

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.
**Birthing Center** *(GR-9N S-11-045-01 CT)*

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-9S 11-060 01 CT)*

Home health care expenses if you are under the care of a physician are covered expenses if:

- the charge is made by a home health care agency; and
- continued hospitalization would otherwise have been required if home health care was not provided, except if you are diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live; and
- the home health care plan covering the home health care is established and approved in writing by such physician within 7 days following termination of a hospital confinement as a resident inpatient for the same condition that caused the hospital stay or one related to it, except if you are diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live, such plan may be so established and approved any time irrespective of whether you were so confined or if so confined, irrespective of such 7 day period; and
- the care starts within 7 days after discharge from a hospital as an inpatient, except if you are diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live; and
- the care is given to you in your home.

Home health care expenses include charges for:

- Part-time or intermittent nursing care by an R.N. or by an L.P.N. under the supervision of an R.N. if the services of an R.N. are not available.
- Part-time or intermittent home health aide services if they are primarily for patient care of a medical or therapeutic nature.
- Physical, occupational, and speech therapy.
- Medical social services to or for your benefit if you are diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live are covered up to $200 and must be provided by a qualified social worker.
- The following to the extent they would have been covered under this Plan if you had remained or had been confined in the hospital:
  - medical supplies;
  - drugs and medicines prescribed by a physician; and
  - lab services.

**Important Reminders**

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

Refer to the *Summary of Benefits* for details about home health care visit maximums.
Skilled Nursing Care *(GR-9N-S-11-065-01 CT)*

Covered expenses include charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care.

This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

**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 CT)*

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.

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

**Limitations**

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

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

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

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

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

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

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

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 CT)*

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

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

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

**Ambulance Service** *(GR 9 NS 11-080 03 CT)*
Covered expenses include charges made by an ambulance, as follows:

**Ambulance Services**
Covered expenses include charges for transportation:

- To a hospital by ambulance, when medically necessary and 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.
- During a covered inpatient stay at a hospital, Skilled Nursing Facility or acute rehabilitation hospital, to transport you for inpatient or outpatient medically necessary treatment when an ambulance is required to safely and adequately transport the member.

**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;
- Your condition is unstable, and requires medical supervision and rapid transport; and
- 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; 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.
- By fixed wing air ambulance from an **out-of-network provider**.

**Autism Spectrum Disorders (GR-9N 11-171-02 CT)**

**Covered expenses** include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including behavioral therapy and Applied Behavioral Analysis) of Autism Spectrum Disorder when ordered by a **physician**, licensed psychologist, or licensed clinical social worker, as part of a Treatment Plan; and

- The **covered expenses** are incurred prior to attainment of age fifteen.

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

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association:

- Autistic Disorder;
- Rett’s Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder--Not Otherwise Specified.

Coverage does not include reimbursement for special education and related services.

Coverage for Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the **Schedule of Benefits**.

**Diagnostic and Preoperative Testing (GR-9N 11-085 03 CT)**

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

- C.A.T. scans;
- Magnetic resonance imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $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.
Bone Marrow Testing
Covered benefits include coverage for expenses arising from human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

Aetna may require that testing be performed in a facility accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time.

Coverage is limited to members who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used in participation in the National Marrow Donor Program.

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.

Important Reminder
- 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.
- 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)
Covered expenses include charges incurred by you for ostomy surgery; including appliances and supplies relating to ostomy including, but not limited to:

- collection devices;
- irrigation equipment and supplies;
- skin barriers; and
- skin protectors.

As used here:

“ostomy” includes colostomy, ileostomy, and urostomy.

**Important Reminder**

A maximum may apply to ostomy appliances and supplies. Please refer to the *Summary of Your Benefits*. Ostomy appliances and supplies shall not be subject to DME maximums, if any.

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

The initial purchase of DME if:

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

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

Replacement of purchased equipment if:

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

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

Covered *Durable Medical Equipment* includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet-Certificate. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

**Important Reminder**

Refer to the *Schedule of Benefits* for details about any applicable *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** *(GR 9N S11-095 CT)*

**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;
- 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.

Cancer Clinical Trials Services (GR-9N-11-095-02 CT)

Clinical trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for the purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic diseases in human beings.

A clinical trial shall be:
- Conducted under the support and guidance of an independent peer-reviewed protocol that has been reviewed and approved by one of the National Institutes of Health, or a National Cancer Institute affiliated cooperative group, the FDA as part of an investigational new drug or device application or exemption, or the Federal Department of Defense or Veterans Affairs; or
- Qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19, 2000 Medicare National Coverage Determination, as amended from time to time.

In order to be eligible for routine patient care costs, Aetna may require:
- Evidence satisfactory to the plan, that the eligible member receiving coverage meets all of the patient selection criteria for the clinical trial, including credible evidence in the form of clinical or preclinical data showing that the clinical trial is likely to have a benefit that is commensurate with the risks of participation;
- Evidence that the appropriate informed consent has been received from the eligible member;
- Copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the eligible member;
- A summary of the anticipated routine patient care costs in excess of the costs of standard treatment;
- Information from the physician or institution seeking to enroll the eligible member in the clinical trial, regarding those items, including any routine patient care costs that are eligible for reimbursement by an entity other than Aetna; and
- Any additional information that may be reasonably required for the review of the request for coverage of the clinical trial.

Covered expenses include charges incurred for medically necessary health care services that are incurred as a result of the treatment being provided for purposes of a clinical trial that would otherwise be covered if such services were not performed pursuant to a clinical trial. These services include those rendered by a physician, diagnostic or laboratory tests, hospitalization, or other services provided to the patient during the course of treatment in the clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if you were not enrolled in a clinical trial and for routine patient care costs incurred for drugs provided to the Member, provided such drugs have been approved by the Federal Food and Drug Association (FDA).

If the services are not available in a hospital that is a network provider, expenses for the services provided at a hospital that is not a network provider shall be paid on the same basis as if the services were provided in hospital that was a network provider.

Covered Medical Expenses do not include:
- the cost of an investigational new drug or device that has not been approved for market for any indication by the FDA;
- the cost of a non-health care service that you may be required to receive as a result of the treatment being provided for the purposes of the clinical trial;
- facility; ancillary; professional services; and drugs costs that are paid for by grants or funding for the clinical trial;
• costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or are performed specifically to meet the requirements of the clinical trial;
• costs that would not be covered under this plan for non-investigational treatments, including but not limited to, items excluded from coverage under this plan;
• transportation; lodging; food; or any other expenses associated with travel to or from a facility providing the clinical trial, for you, a family member or a companion.

Pregnancy Related Expenses (GR 9N S 11-100 CT)

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.

Covered expenses include charges for pregnancy and childbirth expenses at the same level of any other applicable illness or injury. For inpatient care of the mother and newborn child, the plan will pay for a minimum of:

• 48 hours after a vaginal delivery; and
• 96 hours after a cesarean section.

Any decision to shorten such minimum coverages shall be made by the attending physician; in consultation with the mother. In such cases, covered services shall include: home visits; parent education; and assistance and training in breast or bottle-feeding.

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.

Reconstructive or Cosmetic Surgery and Supplies (GR 9N S 11-125 CT)

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

Mastectomy Reconstructive Breast Surgery

To the extent that this booklet-certificate provides coverage for hospital room and board and surgery, covered expense includes expenses for charges incurred in connection with a mastectomy or lymph node dissection, including a minimum of 48 hours of inpatient care following the procedure. Covered expenses also 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.
Coverage will be subject to any coinsurance and maximums applicable to Hospital Services and Surgical Services as shown on the Schedule of Benefits.

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

For maximums, services and supplies involving breast prosthesis and reconstructive surgery post-mastectomy, and reconstructive surgery post-tumor removal refer to Tumor and Leukemia, Wig and Breast Prosthesis section for coverage details.

**Short-Term Rehabilitation Therapy Services** (GR-9N-11-120-01 CT)

**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;
- A home health care agency; 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 Autism Spectrum Disorders, 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 Autism Spectrum Disorders, 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 Autism Spectrum Disorders, 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.
- Allows therapy services, provided in your home, if you are homebound.

**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). Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders. This exclusion does not apply to the following Early Intervention Services when treatment is part of an Individualized Family Service Plan:
  - Cognitive development;
  - Physical development, including vision or hearing;
  - Communication development;
  - Social or emotional development; or
  - Adaptive skills or as diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay.

Refer to the Early Intervention Services provision under the Covered Benefits section of this Certificate for coverage details, including benefit maximums and limitations.

- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, 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;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.
Treatment of Infertility *(GR-9N S-11-135-01 CT)*

**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.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

**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 (GR-9N-11-172-01 CT)
This Plan pays charges incurred for the treatment of mental disorders by behavioral health providers.

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

- Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting.

- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, or as part of partial hospitalization treatment described below.

Partial hospitalization treatment (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a physician. The facility or program does not make a room and board charge for the treatment. Partial hospitalization treatment will only be covered if:

- You would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
- The severity of your condition requires services provided in a partial hospitalization treatment setting.
Important Notes

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

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

Inpatient treatment and certain outpatient treatments must be precertified by Aetna. Refer to the How Your Medical Plan Works section for details.

Please refer to the Schedule of Benefits for any copayments/deductibles, maximums and Maximum Out-of-Pocket Limit that may apply to your mental disorder benefits.

Treatment of Substance Abuse (GR-9N-11-172-01 CT)

This Plan pays charges incurred for the treatment of substance abuse by behavioral health providers and medical addictionologists.

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

- **Inpatient room and board** at the semi-private room rate and other services and supplies that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if the severity of your condition requires services that are only available in an inpatient setting. Treatment in a hospital is covered only when the hospital does not have a separate substance abuse section or unit, or is for treatment of medical complications of substance abuse.

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

- **Outpatient treatment** received while not confined as an inpatient in a hospital, psychiatric hospital, or residential treatment facility, or as part of partial hospitalization treatment described below.

  **Partial hospitalization treatment** (more than 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program for short-term and intensive treatment provided under the direction of a physician. The facility or program does not make a room and board charge for the treatment. Partial hospitalization treatment will only be covered if:

  - You would need a higher level of care (for example, inpatient, residential, crisis stabilization) if you were not admitted to this type of facility or program; and
  - The severity of your condition requires services provided in a partial hospitalization setting.

Important Notes:

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

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

Inpatient treatment and certain outpatient treatments must be precertified by Aetna. Refer to How Your Medical Plan Works section for details.

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.
Inherited Metabolic Disease Formula Services (GR-9N 11-190-01-CT)

Covered expenses include charges incurred by you or your covered dependent for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases.

Covered expenses also include specialized formulas when such specialized formulas are necessary for the treatment of a disease or condition and are administered under the direction of a physician.

As used here,

- “inherited metabolic disease” means:
  - HIV;
  - maple syrup urine disease;
  - phenylketonuria and other metabolic diseases;
  - homocystinuria;
  - hypothyroidism;
  - biotinidase deficiency;
  - galactosemia;
  - congenital adrenal hyperplasia;
  - sickle cell disease;
  - fatty, amino and organic acid disorders;
  - cystic fibrosis; and
  - such other tests for inborn errors of metabolism as are prescribed by the Department of Health
- “Amino acid modified preparation(s)” means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

“Low protein modified food product(s)” means a product formulated to have less than 1 gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

"Specialized formula(s)" means a nutritional formula for your covered dependent up to age 12 that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under the medical supervision in the dietary management of specific diseases.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) (GR-9N 11-180-02-CT)

For your covered dependent under age 19, for a craniofacial disorder covered expenses, please refer to the Craniofacial Disorder section for coverage details.

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.

Craniofacial Disorder Expenses
Covered medical expenses include charges incurred by the covered person for covered treatment given to the covered person’s dependent under age 19 for a craniofacial disorder, including congenital cleft lip or palate. Covered treatment does not include cosmetic surgery.

As used here:

“Covered treatment” means orthodontic treatment and appliances prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.

“Craniofacial team” means a multidisciplinary group of practitioners that coordinates care for a child with congenital or acquired abnormalities of the craniofacial complex, including structures in the skull, face and neck.

Accidental Ingestion of Controlled Substance Services (GR-9N 11-190-01CT)
Covered expenses include charges incurred by you or your covered dependent for the accidental ingestion of controlled substances.

As used here, “Controlled substances” means a drug or other substance listed in the Current Physicians' Desk Reference as schedule I, II, III, IV, or V; of the Federal Controlled Substances Act of 1970, Title 21. "Controlled substances" does not include distilled spirits, wine, malt beverages, or tobacco.

Hypodermic Needle Services (GR-9N 11-190 01 CT)
Covered expenses will be paid on the same basis as any other applicable expenses under this plan, and include expenses incurred by you or your covered dependent for hypodermic needles and syringes used:

- in the treatment of diabetes; or
- in connection with other injectable drugs provided that coverage for such injectable prescription drugs is provided elsewhere in this Booklet-Certificate.
Pain Management Benefits (GR-9N 11-190 02 CT)

Covered expenses include charges incurred by you or your covered dependent for pain treatment ordered by a pain management specialist which may include all means necessary:

- to make the diagnosis and development of a treatment plan; and
- to prescribe medications and procedures.

As used here:

“Pain” means a sensation in which you or your cover dependent experiences severe discomfort, distress, or suffering due to provocation of sensory nerves.

“Pain management specialist” means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist, or radiation oncologist with additional training in pain management.

If your plan covers prescriptions drug and during the course of your treatment, if you are prescribed a brand name prescription medication by your physician for pain treatment, you will not be required to use any alternative brand name prescription drug or over-the-counter drug prior to use. However, a therapeutically equivalent generic drug may be prescribed.

Lyme Disease Treatment Services (GR-9N 11-190 01 CT)

Covered expenses include charges incurred by you or your covered dependent for Lyme Disease Treatment, and includes:

- 30 days of intravenous antibiotic therapy;
- 60 days of oral antibiotic therapy; and
- further necessary treatment if recommended by a physician.

Medical Plan Exclusions (GR-9N 28-019-07)

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 insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug coverage. Those additional exclusions are listed separately under the What The Plan Covers section for each of these benefits.

- Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan’s Test) treatment of non-specific candida sensitivity, and urine autoinjections.
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.
- Any non-emergency charges 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:**

- 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**, or 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, alveolecotomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits, and splints, neck braces, compresses, and other devices not intended for reuse by another patient. This does not apply to ostomy related supplies or to the supplies related to the testing and treatment of diabetes.

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;
- Implantable drugs and associated devices;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications except in connection with the testing and treatment of diabetes;
- Any prescription drugs, injectibles, 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. This exclusion does not apply if you are diagnosed by a physician as infertile. Refer to the Treatment of Infertility provision under What the Plan Covers section.
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.

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;
- 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, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

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.

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.

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. This exclusion shall not apply to the treatment of mental or nervous conditions.

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.

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 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 Pharmacy Benefit (GR-9N 12-005 06 CT)

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 prescription drug plan. This Booklet-Certificate explains:

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

A few important notes to consider before moving forward:

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

Notice

The plan does not cover all prescription drugs, medications and supplies. Refer to the Prescription Drug Limitations section below and the Exclusions section of this Booklet-Certificate.

- Covered expenses are subject to cost sharing requirements as described in the Cost Sharing section below and the Schedule of Benefits.

Getting Started: Common Terms (GR-9N 12-010 01 CT)

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 or an affiliate.

**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 or an affiliate.

**Network pharmacy** is a description of a retail, mail order or specialty pharmacy that has entered into a contractual agreement with Aetna for the provision of covered services to you and your covered dependents at a negotiated charge. 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 to reduce their fees and does not participate in the Aetna 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 or an affiliate, which includes both brand-named prescription drugs and generic prescription drugs. This list is subject to periodic review and changes 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.

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. An updated copy of the list of Self-injectable Drugs shall be available upon request or may be accessed at the Aetna website, at www.aetna.com. The list is subject to change by Aetna or an affiliate.

Accessing Pharmacies and Benefits

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

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

Accessing Network Pharmacies and Benefits

You may select a network pharmacy from Aetna’s on-line provider directory which can be found 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 at the number on your ID card.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network pharmacy benefits. The network pharmacy will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the network pharmacy. You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.
Emergency Prescriptions
When you need a prescription filled in an emergency or urgent care situation, or when you are traveling, you can obtain network pharmacy benefits by filling your prescription at any network 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 pharmacy 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 be responsible for the copayment for each prescription or refill as specified in the Schedule of Benefits. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.

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

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

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

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

Pharmacy Benefit
The plan covers charges for medically necessary outpatient prescription drugs for the treatment of an illness or injury, subject to the Prescription Drug Limitations section below 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. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug guide.
Preferred 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.

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

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 retail pharmacy.

Mail Order Pharmacy Benefits
Outpatient prescription drugs are covered when dispensed by a mail order pharmacy or a CVS/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.

Other Covered Expenses (GR-9N-S-13-005-01 CT)
The following prescription drugs, medications and supplies are also covered expenses under this Coverage.

Off-Label Use (GR-9N-S-13-005-01 CT)
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 Pharmacopeia 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, in Aetna’s sole discretion, be subject to Aetna requirements or limitations.

Diabetic Supplies (GR-9N 13-012 02 CT)
Covered expenses include but are not limited to the following diabetic supplies upon prescription by a Prescriber:

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

Contraceptives. Covered expenses include charges made by a network pharmacy for the following contraceptive methods when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing:

- Female contraceptives that are generic prescription drugs and brand-name prescription drugs.
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives.

Refer to the Copay and Deductible Waiver section of your Schedule of Benefits.

Important Notes:

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

- such contraceptive methods are not available within the same therapeutic drug class; or
- a generic equivalent, or generic alternative, within the same therapeutic drug class is not available; and

- you are granted a medical exception. Refer to Medical Exceptions in the Precertification section for information on how you or your prescriber can obtain a medical exception.

2. A generic equivalent contains the identical amounts of the same active ingredients as the brand-name prescription drug. A generic alternative is used for the same purpose, but can have different ingredients or different amounts of ingredients.

**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 13-015 07)**

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

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

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 in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

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

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

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.

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

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

Depending on the form and packing of the product, some prescription drugs are limited to 100 units excluding insulin dispensed per prescription order or refill.

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

Specialty care prescription drugs may have limited access or distribution and are subject to supply limits.

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

Pharmacy Benefit Exclusions (GR-9N 28 (06-10))
Not every health 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 prescription drug exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

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 if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet-Certificate. This also includes prescription drugs or supplies if:

- Such 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.

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

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.
Contraceptive prescription drugs, devices, services and supplies (except as specifically described in the Preventive Care Benefits and Additional Covered Expenses section) including:

- Services associated with the prescribing, monitoring and/or administration of prescription drug contraceptives and devices.
- Female contraceptives that are brand-name prescription drugs; and
- FDA-approved female brand-name emergency contraceptives.

Contraception – Male condoms.

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

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Compounded prescriptions.

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

Dietary supplements including medical foods, unless as specifically covered under the What the Plan Covers section.

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

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

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;

except as described in the What the Plan Covers section.

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

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;
- Injectable agents, except insulin;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available, unless medically necessary;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the specialty pharmacy network.
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

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

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 drugs dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

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

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

Prescription drugs that are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

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

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

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

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

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

Replacement of lost or stolen prescriptions.

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

Tobacco use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings. This includes medications, nicotine patches and gum.

Ambulance Service (GR-9N 11-080 02)
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.
- During a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, to transport you for inpatient or outpatient medically necessary treatment when an ambulance is required to safely and adequately transport you.

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;
- Your condition is unstable, and requires medical supervision and rapid transport; and
- 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 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.

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

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;
- 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 of active 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. Upon cancellation or discontinuance of coverage under the Policy, the employer shall furnish each employee notice of such cancellation or discontinuation not less than 15 days preceding the effective date of the cancellation or discontinuance.

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-30-015-06 CT)

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 overall 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 the case of a dependent child:
Coverage of your dependent child ends no earlier than the policy anniversary date on, or after whichever of the following occurs first, the date on which the child:

- Becomes covered under another group health plan through their own employment; or
- Attains the age of twenty-six (26).

A stepchild will be covered on the same basis as a biological child.

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 CT)

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

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-CT)

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 a mental 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-CT)*

**Extension of Benefits**

**Extension of Benefit While You Are Receiving Inpatient Care**

When there is a succeeding carrier:

If you are receiving inpatient care in a hospital or skilled nursing facility on the date coverage under this Booklet-Certificate terminates such care is covered in accordance with the Booklet-Certificate only for the specific medical condition causing that confinement or for complications arising from the condition causing that confinement, until the earlier of:

1. the date of discharge from such inpatient stay,
2. determination by the Plan Medical Director in consultation with the attending physician, that care in the hospital or skilled nursing facility is no longer medically necessary;
3. the date the contractual benefit limit has been reached;
4. the date you become covered for similar coverage from another health benefits plan; or
5. 12 months of coverage under this extension of benefits provision.

The extension of benefits shall not extend the time periods during which you may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of premium for such coverage. However, in the event you are confined in a hospital on the date the plan terminates, payment of your premium for the period of the extension of benefit is not required.

When there is no succeeding carrier, under Connecticut State Law:

When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are confined to a health care facility, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

The extension will apply until the date the covered individual is not confined to a health care facility or the date that is twelve calendar months following the date the policy was discontinued, whichever is earlier.

Extension of benefits will be available provided that evidence of the facility confinement is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

**Extension of Benefits Upon Total Disability Under Connecticut State Law:**

The extension of benefits shall not extend the time periods during which you may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of premium for such coverage. However, in the event you are totally disabled on the date the plan terminates, payment of your premium for the period of the extension of benefit is not required.
When there is no succeeding carrier:
When there is no succeeding group health insurance plan sponsored by the employer and insured by another carrier, for covered individuals who are totally disabled, on the date the policy is discontinued, the group health insurance plan shall provide coverage for the confinement including professional services and supplies rendered during the confinement in the health care facility and for all services related to the disabling condition, as applicable, without premium payment, according to the terms of its plan.

The extension will apply until the date the covered individual is no longer totally disabled, or the date that is 12 calendar months following the date the policy was discontinued, whichever is earlier.

Extension of benefits will be available provided that evidence of any disabling condition is submitted within one year of the termination of the plan and claims for coverage are submitted in accordance with the plan terms.

When there is a succeeding carrier, and you are not confined:
If you are totally disabled and not confined in a health care facility on the date of discontinuance of the Group Policy when the group health insurance plan is replaced by a succeeding group health insurance plan the succeeding carrier shall be responsible for all coverage for the totally disabled individual, including transition of care benefits that provide the individual with a reasonable opportunity to use their current health care provider(s) for a period of time that is clinically appropriate for the treatment of the disabling condition. During the transitional period, benefits under the succeeding carrier's plan for treatment of the disabling condition will not be reduced because of lack of participation in the succeeding carrier's network or lack of certification by the succeeding carrier for services pre-certified by the prior carrier. Nothing herein shall be construed as authorizing or requiring medical necessity certification procedures between the managed care organization and the provider that are not set forth in the contract between the managed care organization and the provider.

The extension will apply until the earlier of the date that you: are no longer totally disabled; have exhausted the benefits available for treatment of that condition; or after a period of 12 months in which benefits under such coverage are provided to you.

Important Note
If the Extension of Benefits provision outlined in this section applies to you or your covered dependents, see the Converting to an Individual Health Insurance Policy section for important information.

COBRA Continuation of Coverage (GR.9N:31-025-01 CT)

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.

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<th>Qualifying Event Causing Loss of Health Coverage</th>
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<td>You are a retiree eligible for health coverage and your former employer files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>

If the termination (other than gross misconduct), leave of absence or reduction in hours results from your eligibility to receive Social Security income, this continuation for you and any covered dependents may continue until midnight of the day preceding your eligibility for Medicare.

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.
- Quality 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.

Individual conversion coverage is also available to Connecticut residents through the Connecticut Health Reinsurance Association.
Converting to an Individual Medical Insurance Policy

Eligibility
You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical 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 eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- 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.
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 (GR-9N-33-015-01 CT)

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.

Multiple Coverage Under This Plan

If a person is covered under This Plan both as an employee and a dependent or as a dependent of 2 employees, the following will also apply:

- The person's coverage in each capacity under this Plan will be set up as a separate "Plan".
- The order in which various plans will pay benefits will apply to the "Plans" set up above and to all other plans.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under the Plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.
Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
When You Have Medicare Coverage

(UPON-9N-33-020-02 CT)

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.

If you are enrolled in Medicare, coverage under this Booklet-Certificate will pay for such benefits as follows:

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-CT)

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-CT)

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-32-005-05-NE)

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.

Entire Contract - Changes

This Booklet-Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Additional Provisions (GR-9N-32-005-05-NE)

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-32-005-03-CT)

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

All coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, Aetna will not accept an assignment to an out-of-network provider, including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach, or alleged breach, of the terms of this group insurance policy.

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

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-CT)

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-CT)

Aetna may rescind your coverage if you, or the person seeking coverage on your behalf:

- Performs an act, practice or omission that constitutes fraud; or
- Makes an intentional misrepresentation of material fact.

You will be given 30 days advance written notice of any rescission of coverage.

As to medical and prescription drug coverage only, you have the right to an internal Appeal with Aetna and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.

## Subrogation and Right of Reimbursement

To the extent permitted by law

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 CT)

Health Coverage

If a benefit payment is made by Aetna, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, Aetna has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

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

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 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 PCP provides care for you or a covered dependent, or care is provided by a network provider (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

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, you will be excluded from medical expense coverage (except Vision Care), if any, 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.

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 CT)**

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.*

**Appeals Procedure (GR-9N-32-050-01 CT)**

**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 coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

**Clinical Peer:** A physician or other health care professional who holds an unrestricted license in a state within the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and concerning mental health and substance abuse conditions, holds a national board certification in psychiatry or psychology and has training or clinical experience in the treatment of substance use disorders or mental disorders. In the case of children or adolescents, holds a national board certification in child and adolescent psychiatry or child and adolescent psychology, and has training or clinical experience in the treatment of child or adolescent mental health disorders or substance use disorders.

**Appeal:** A written request to Aetna to reconsider an *adverse benefit determination.*

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

**Concurrent Care Claim Extension:** A request to extend a course of treatment that was previously approved.

**Concurrent Care Claim Reduction or Termination:** A decision to reduce or terminate a course of treatment that was previously approved.

**External Review:** A review of an *adverse benefit determination* or a *final adverse benefit determination* by an Independent Review Organization/External Review Organization (IRO) assigned by the State Insurance Commissioner and made up of physicians or other appropriate health care providers. The IRO 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.
Grievance. A written complaint, or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a Member, regarding the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made due to utilization review, claims payment, handling or reimbursement for health care services; or any matter pertaining to the contractual relationship between the Member and Aetna.

Pre-service Claim: Any claim for medical care or treatment that requires approval before the medical care or treatment is received.

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”

Urgent Care Claim: Any claim for medical care or treatment in which a delay in treatment could:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Cause you to suffer severe pain that cannot be adequately managed without the requested medical care or treatment; or
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

Full and Fair Review of Claim Determinations and Appeals
As to medical and prescription drug claims and appeals only, Aetna will provide you with any new or additional evidence considered and rationale, relied upon, or generated by us in connection with the claim at issue. This will be provided to you in advance of the date on which the notice of the final adverse benefit determination is required to be provided so that you may respond prior to that date.

Prior to issuing a final adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of final adverse determination is required.

Claim Determinations
Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. As to medical and prescription drug claims only, 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 72 hours after the claim is made.

If more information is needed to make an urgent claim decision, Aetna will notify the claimant within 72 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier to occur:

- The receipt of the additional information; or
- The end of the 48 hour period given the physician to provide Aetna with the information.

If the claimant fails to follow plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.
**Pre-Service Claims**

**Aetna** will notify you of a pre-service claim decision as soon as possible, but not later than 15 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 15 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 15 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

**Post-Service Claims**

**Aetna** will notify you of a post-service claim decision as soon as possible, but not later than 30 calendar days after the claim is made. **Aetna** may determine that due to matters beyond its control an extension of this 30 calendar day claim decision period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if **Aetna** notifies you within the first 30 calendar day period. If this extension is needed because **Aetna** needs more information to make a claim decision, the notice of the extension shall specifically describe the required information. The patient will have 45 calendar days, from the date of the notice, to provide **Aetna** with the required information.

**Concurrent Care Claim Extension**

Following a request for a concurrent care claim extension, **Aetna** will notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. A decision will be provided not later than 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

**Concurrent Care Claim Reduction or Termination**

**Aetna** will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

**Aetna** would notify the provider at least three business days prior to the scheduled date of admission, service, procedure or extension of stay, that the pre-authorization has been reversed or rescinded on the basis of medical necessity, fraud or lack of coverage. If you file an appeal, coverage under the plan will continue, without liability, for the previously approved course of treatment until a final appeal decision is rendered.

**Grievances/Complaints**

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Member Services within 180 days. 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 20 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.

You may contact the Department of Insurance for assistance regarding any grievance or appeal at the following address:

State of Connecticut Insurance Department  
Consumer Affairs Department  
P.O. Box 816  
Hartford, CT 06142-0816  
(860) 297-3900 or 1-800-203-3447  
cid,ca@ct.gov.

Or, the Office of Healthcare Advocate at:

State of Connecticut  
Office of the Healthcare Advocate
Appeals of Adverse Benefit Determinations

A review of an Appeal of an adverse benefit determination shall be provided by clinical peers. They not have been involved in making the adverse benefit determination.

You may submit an appeal if Aetna gives notice of an adverse benefit determination. A final adverse benefit determination notice may also provide an option to request an External Review (if available).

You have 180 calendar days with respect to Group Health Claims following the receipt of notice of an adverse benefit determination to request your Level One Appeal. Your appeal must be submitted in writing and must include:

- Your name.
- 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.

You may also choose to have another person (an authorized representative) make the appeal on your behalf. You must provide written consent to Aetna.

You may be allowed to provide evidence or testimony during the appeal process in accordance with the guidelines established by the Federal Department of Health and Human Services.

Appeal - Group Health Claims
A review of an Appeal of an adverse benefit determination shall be provided by clinical peers. 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 72 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 30 calendar days of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 60 calendar days of receipt of the request for an appeal.

External Review (GR-9N-32.031.01 CT)

You may receive an adverse benefit determination or final adverse benefit determination because Aetna determines that:

- The claim involves medical judgment;
- The care is not necessary or appropriate; or
- A service, supply or treatment is experimental or investigational in nature.
- The adverse benefit determination relates to eligibility, or a rescission, defined as a cancellation or discontinuance of coverage which has a retroactive effect (unrelated to failure to pay required contribution).
In these situations, you may request an External Review if you or your provider disagrees with Aetna’s decision.

To request an External Review, any of the following requirements must be met:

- You have received an adverse benefit determination notice by Aetna, and Aetna did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
- You have received a final adverse benefit determination notice of the denial of the claim by Aetna.
- Your claim was denied because Aetna determined that the care was not necessary or appropriate or was experimental or investigational.
If the Adverse Benefit Determination relates to an Experimental or Investigational Procedure treatment, the Physician must certify in writing, that the following criteria is met:

1. The Member has a terminal medical condition, life threatening condition, or a seriously debilitating condition, and
2. The Member has a condition that qualifies under one or more of the following: standard health care services or treatments have not been effective in improving the Member’s condition; or standard health care services or treatments are not medically appropriate for the Member; or there is no available standard health care service or treatment covered under the Member’s health care plan, that is more beneficial than the requested or recommended health care service or treatment; and
3. The health care service or treatment recommended and which has been denied, is likely to be more beneficial to the Member than any available standard health care service or treatment.

- You qualify for an expedited review as explained below.
- As to dental, vision and hearing claims only, the cost of the initial service, supply or treatment in question for which you are responsible exceeds $500.

The notice of adverse benefit determination or final adverse benefit determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to the Connecticut Insurance Department within 120 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

**Mailing Instructions:**
Please mail your application for external review to:

Connecticut Insurance Department  
Attention: External Review  
P.O. Box 816  
Hartford, CT 06142-0816

For overnight delivery only: please mail your application for external review to:

Connecticut Insurance Department  
Attention: External Review  
153 Market Street, 7th Floor  
Hartford, CT 06103

The Connecticut Insurance Department will forward the appeal to Aetna, and Aetna will conduct a preliminary review to determine if the appeal is eligible. If it is determined not to be eligible, the Member may then appeal to the Commissioner.

The Connecticut Insurance Department will assign the IRO that will conduct the review of your claim. The IRO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna’s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the IRO usually within 45 calendar days of Aetna’s receipt of your request form and all the necessary information.

An expedited review is possible if your physician certifies (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 an expedited 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, or mental health or substance abuse disorders.

Expedited reviews are decided within 72 hours after the IRO receives the request, except in the case of experimental or investigational reviews, which have a 5 day timeframe, and in the case of an expedited review involving a substance abuse disorder or for a co-occurring mental disorder, or mental disorder requiring inpatient services, partial hospitalization, residential treatment or intensive outpatient services necessary to prevent an inpatient setting, the review will be decided as expeditiously as the member’s medical condition requires, but not later than 24 hours after the IRO receives the request to conduct this review.

The decision is binding on Aetna, except to the extent that Aetna has other remedies under state or federal law.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to Aetna. Aetna is responsible for the cost of sending this information to the IRO and for the cost of the external review except for dental, vision and hearing claims.

You may contact the Department of Insurance for assistance regarding any External Review or Expedited External Review, at the following address:

State of Connecticut Insurance Department
Consumer Affairs Department
P.O. Box 816
Hartford, CT 06142-0816
(860) 297-3900 or 1-800-203-3447
cid, ca@ct.gov.

Or the Office of Healthcare Advocate at:

State of Connecticut
Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
1-866-297-3992
Healthcare.advocate@ct.gov.

For more information about the Appeals Procedure or External Review processes, call the Member Services telephone number shown on your ID card.
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 01)*

**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**
A licensed facility, organization or other health care provider furnishing diagnostic and therapeutic services for treatment of mental or nervous conditions acting within the scope of the applicable license. This includes:

- Hospitals;
- Psychiatric hospitals;
- Residential treatment facilities;
- Psychiatric physicians;
- Psychologists;
- Social workers;
- Psychiatric nurses;
- Addictionologists; and
- Other alcoholism, drug abuse and mental health providers or groups, involved in the delivery of health care or ancillary services.

**Birthing Center**
A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a specialist in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
• Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  – Complications arise during labor; or
  – A child is born with an abnormality which impairs function or threatens life.
• Accepts only patients with low-risk pregnancies.
• Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
• Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
• Keeps a medical record on each patient and child.

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

Brand-Name Prescription Drug
A 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

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 CT)*

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**.

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-visit
An E-visit is an online internet consultation between a network physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.

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
A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
- drug;
- device;
- procedure; or
- treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

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.

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 administration.
- Meets licensing standards.

Home Health Care Plan
This is a plan that provides for continued care and treatment of an illness or injury.

Hospice Care
This is care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program.
Hospice Care Agency
An agency or organization that meets all of the following requirements:

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One physician;
  - One R.N.; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
- Assesses the patient's medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility
A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.
**Hospital**
An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

*In no event* does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

**Hospitalization**
A continuous confinement as an inpatient in a **hospital** for which a room and board charge is made.

**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.
**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.

**Late Enrollee (GR-9N 34-055 01)**

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.

**Mail Order Pharmacy (GR-9N 34-065 03 CT)**

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 because they are not Covered Expenses or precert penalties made because a required precertification 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, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". A mental disorder does not include: mental retardation, learning disorders, motor skill disorders, communication disorders, caffeine-related disorders, relational disorders, and additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

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.

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; or
- Furnished or arranged by your PCP.

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
This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.
Out-of-Network Service(s) and Supply(ies) (GR-9N-34-075-01 CT)

Health care service or supply that is:

- Furnished by an out-of-network provider, or
- Not furnished or arranged by your PCP.

Out-of-Network Provider

A health care provider or pharmacy who has not contracted with Aetna, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat mental disorders and substance abuse. 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.

Partial Hospitalization Treatment

A plan of medical, psychiatric medical, nursing, counseling, and/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 hospitalization.
- It is supervised by a psychiatrist who weekly reviews and evaluates its effect.
- Day care treatment is considered partial hospitalization 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 a mental or nervous condition; 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.

Preferred Network Pharmacy
A network retail pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient prescription drugs that we have identified as a preferred network pharmacy.

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.
- Disposable hypodermic needles and syringes for the purpose of administering injectable drugs for a covered medical condition provided that such injectable prescription drugs are covered under the Policy.
- Injectable insulin; disposable needles; and syringes; when prescribed and purchased at the same time as insulin; and disposable diabetic supplies.

Primary Care Physician (PCP)
This is the network provider who:

- Is selected by a person from the list of primary care physicians in the directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on Aetna's records as the person's PCP.
Psychiatric Hospital
This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of mental or nervous conditions.
- 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 mental or nervous conditions.

R (GR-9N-34.090-02 CT)

Recognized Charge (GR-9N-34.090-02 CT)
The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 80th percentile of the Prevailing Charge Rate;
  - for the Geographic Area where the service is furnished.

As to prescription drug expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the Average Wholesale Price (AWP) or other similar resource. Average Wholesale Price (AWP) is the current average wholesale price of a prescription drug listed in the Medi-Span weekly price updates (or any other similar publication chosen by Aetna).

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
whether there are any other characteristics that may modify or make a particular service unique; and
when a charge includes more than one claim line, whether any services described by a claim line are part of or 
incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally 
accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-
reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent 
with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in 
the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

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.

Important Note
Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the 
date that the service or supply was provided.

Additional Information
Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or 
supply. Log on to Aetna Navigator to access the "Estimate the Cost of Care" feature. Within this feature, view our 
"Cost of Care" and "Member Payment Estimator" tools, or contact our Customer Service Department for assistance.

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) Not applicable to Substance 
Abuse. See Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- Has, on-site, licensed Behavioral Health Providers 24 hours per day.
- Provides a comprehensive patient assessment.
- Provides living arrangements that foster community living and peer interaction and are consistent with 
developmental needs.
- Offers group therapy sessions.
- Has the ability to involve family and other support systems in therapy.
- Provides access to at least weekly sessions with a psychiatric physician or psychologist for individual 
psychotherapy.
- Has peer oriented activities.
- Is managed by a licensed Behavioral Health Provider who functions under the direction and supervision of a psychiatric physician.
- Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any applicable licensing standards established by the jurisdiction in which it is located.
- Charges patients for its services.

**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/7 days 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 34-95-10)**

**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, as determined by Aetna, in which network providers for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N., and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental or nervous conditions.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, drug abuse or mental or nervous conditions.

Skilled Nursing Services
Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license.
- The services are not custodial.
Specialist
A physician who practices in any generally accepted medical or surgical sub-specialty.

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

Specialty Care Drugs
Injectable, infusion and oral prescription drugs that are prescribed to address complex, chronic diseases with associated co-morbidities. You can access the list of these specialty care prescription drugs by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at www.aetna.com

Specialty Pharmacy Network
A network of pharmacies designated to fill specialty care drugs.

Stay
A full-time inpatient confinement for which a room and board charge is made.

Step Therapy
A form of precertification under which certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step therapy drugs is subject to change by Aetna or an affiliate. An updated copy of the list of drugs subject to step therapy shall be available upon request by you or may be accessed on the Aetna website at www.Aetna.com/formulary.

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

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:

- 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.

**Telemedicine**
A telephone or internet based consult with a provider that has contracted with Aetna to offer these services.

**Terminally Ill (Hospice Care)**
Terminally ill means a medical prognosis of 12 months or less to live.

**Therapeutic Drug Class**
A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

**Urgent Admission**
A hospital admission by a physician due to:

- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury.
- The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

**Urgent Care Facility**
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

**Urgent 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.
  - Charges for its services and supplies.
  - 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.

**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**.
Confidentiality Notice
Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at www.aetna.com.
Additional Information Provided by

SAMPLE

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
SAMPLE

Employer Identification Number:
SAMPLE

Plan Number:
SAMPLE

Type of Plan:
SAMPLE

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
SAMPLE

Agent For Service of Legal Process:
SAMPLE

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
SAMPLE

Source of Contributions:
SAMPLE

Procedure for Amending the Plan:
SAMPLE

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:
Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have
sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement of Rights under the Newborns' and Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act
Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

1. all stages of reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to the federal Patient Protection and Affordable Care Act (PPACA) may not be included in the enclosed 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 PPACA.

The following is a summary of the requirements under PPACA.

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

2. For grandfathered and non-grandfathered plans:
   a. Any overall plan calendar year and lifetime dollar maximums no longer apply.
   b. Any calendar year or annual and lifetime dollar maximum benefit that applies to an "Essential Service" (as required by PPACA and defined by Aetna) for Preferred Care and Non-Preferred Care no longer applies. Essential Services will continue to be subject to any coinsurance; copays; deductibles; other types of maximums (e.g., day and visit maximums); referral and certification rules; and any exclusions and limitations that apply to these types of covered medical expenses under your plan.
   c. If your Plan includes a pre-existing condition limitation provision, including one that may apply to transplant coverage, then this provision will not apply to a person under 19 years of age.
d. The eligibility rules for children have been changed. A child will now be eligible to enroll if he or she is under 26 years of age. Any rule that they be a full-time student, not married or solely dependent upon you for support will not apply. **Please Note:** For grandfathered plans only, if your child (under age 26) is eligible for employer based coverage other than through a parent’s plan, then that child may not be eligible to enroll in this Plan. Contact your policyholder for further information.

e. If your coverage under the Policy is rescinded, Aetna will provide you with a 30 day advance written notice prior to the date of the rescission.
IMPORTANT HEALTH CARE REFORM INFORMATION

Some language changes in response to 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:
     - 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.
If your Aetna plan 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.