

**PIMA COUNTY
EMPLOYEE
MEDICAL
BENEFITS PLAN**

**Summary Plan Description for the
Aetna Choice POS II High Deductible
Health Plan (HDHP) Option**

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



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

Preface

Pima County (“the Employer” or “Pima County”) has established the “Pima County Employee Medical Benefits Plan” (the “Plan”) to provide designated medical benefits for eligible employees of Pima County and their eligible dependents. The Plan is a self-insured program meaning that benefits are provided from the general assets of Pima County and are not paid through a policy or policies of insurance.

Pima County has contracted with Aetna in order to secure access to their network of medical providers, for the processing of medical claims, and to provide certain administrative services under the Plan. Pima County has contracted with CVS Caremark in order to secure access to their network of pharmacy providers, for the processing of pharmacy claims, and to provide certain administrative services under the Plan. The Plan is not, however, insured with Aetna, its affiliates or any other insurer.

This Summary Plan Description describes the rights and obligations of employees who elect coverage under the Plan’s “Aetna Choice POS II” option, what the Plan covers under that option, and how benefits are paid for that coverage. References to “you” and “your” as used in this Summary Plan Description refer to Employees eligible for and electing coverage under the Aetna Choice POS II option, and covered dependents, unless the context indicates otherwise. References to “we” or “us” will refer to Pima County unless the context indicates otherwise.

It is your responsibility to understand the terms and conditions in this *Summary Plan Description*, the *Schedule of Benefits* and any amendments.

This *Summary Plan Description* replaces and supersedes all **prior Plan documents** describing coverage for the medical benefits described in this *Summary Plan Description* that you may previously have received. As the Plan is not covered by a separate policy or policies of insurance, this Summary Plan Description also services as the official Plan Document. While your Employer may distribute additional materials or summaries describing various benefits under the Plan from time to time, this Summary Plan Description (and any subsequent Plan amendments) will control in the event of a conflict. The term “booklet” as may be used by Aetna refers to this “Summary Plan Description”.

Certain terms have special meanings for purposes of the Plan. We have pointed out some of these key terms in bold type throughout the Summary Plan Description to call attention to the fact that they may be subject to special definitions. A listing of defined terms appears in the *Glossary* section to the Summary Plan Description.

Pima County reserves the right to amend or terminate this Plan at any time.

Reference Information when contacting Aetna regarding the Plan:

Employer:	Pima County
Contract Number:	863646
Effective Date:	July 1, 2020
Issue Date:	July 1, 2020
Summary Plan Description Number:	1
Plan Year:	July 1 – June 30

Coverage for You and Your Dependents

Health Expense Coverage

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

Coverage under this Plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Summary Plan Description* for more information about your coverage.

Treatment Outcomes of Covered Services

Neither Pima County nor **Aetna** are providers of health care services and therefore are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive. All health care providers under the Plan, including hospitals, institutions, facilities or agencies, are independent contractors and are not agents or employees of Pima County or the Plan. Providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

When Your Coverage Begins

Who Is Eligible

How and When to Enroll

When Your Coverage Begins

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

Who Is Eligible

Employees

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

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

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a regular full-time, part-time, or variable employee hired to work and receiving pay for twenty (20) or more hours per week, or forty (40) or more hours per pay period; or a temporary employee extended beyond the first six (6) months of employment hired to work and receiving pay for a minimum of twenty (20) hours per week, or forty (40) hours per pay period.

Probationary Period

Once you enter an eligible class, you will need to complete the probationary period before your coverage under this Plan begins.

Determining When You Become Eligible

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

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this Plan, your coverage eligibility date is the effective date of the Plan.

After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this Plan, your coverage eligibility date is the first day of the month coinciding with or next following the date you complete 30 days of continuous service with your Employer. This is defined as the probationary period. If you had already satisfied the probationary period before you entered the eligible class, your coverage eligibility date is the date you enter the eligible class.

Obtaining Coverage for Dependents

Your dependents can be covered under this Plan. You may enroll the following dependents:

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

Your employer may require documentation and proof of dependent status to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for a Domestic Partner or Same Sex Spouse

To be eligible for domestic partner coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership on a form approved by your Employer for purposes of the Plan. As domestic partner coverage is not currently treated the same as spousal coverage by the Internal Revenue Service, benefits for a domestic partner spouse or domestic partner children may result in taxable income reported on your W-2. You should consult your personal tax advisor regarding the tax impact of this coverage.

The term “spouse” for purposes of the Plan shall include a same sex spouse as recognized by the Internal Revenue Service in Revenue Ruling 2013-17. Under this guidance, the IRS has adopted a general rule recognizing the marriage of same-sex spouses when the marriage is validly entered into in a domestic or foreign jurisdiction whose laws authorize the marriage of two individuals of the same sex, even if the married couple later resides in a domestic or foreign jurisdiction that does not recognize the validity of same-sex marriages. The IRS ruling does not cover domestic partners, civil unions or other similar formal relationships that may be recognized in some states but are not denominated as a marriage. Documentation demonstrating compliance with IRS Revenue Ruling 2013-17 will be required.

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; and
- Any children for whom you are responsible under court order.

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

Important Reminder

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

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

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with Plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner required by the Plan. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your Employer will determine the amount of your Plan contributions, which you will need to agree to before you can enroll. Your Employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember Plan contributions are subject to change.

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

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

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete an on-line enrollment change form with your Employer within the 31-day enrollment period.

Late Enrollment

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

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

However, you and your eligible dependents may not be considered **Late Enrollees** if you qualify for one of the circumstances described in the “Special Enrollment Periods” section below.

Annual Enrollment

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

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

Special Enrollment Periods

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

Loss of Other Health Care Coverage

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

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
 - You or your dependents were covered under 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; or
- With respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage.
- 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;
- 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of **creditable coverage** must be provided to your employer or the party it designates. 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 an on-line enrollment change form through your Employer. The change must be completed and returned to your Employer 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 your Employer prior to the dependent enrollment.

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.

Coverage for the dependent will become effective on the date Pima County receives the court order.

Under a QMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits.

Note: Certain QMCSO's are governed by the Employee Retirement Income Security Act (ERISA). This Plan is a governmental Plan exempt from ERISA.

When Your Coverage Begins

Your Effective Date of Coverage

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

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

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

Important Notice:

You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

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

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

How Your Medical Plan Works

Common Terms

Accessing Providers

Precertification

It is important that you have the information and useful resources to help you get the most out of your Plan. This Summary Plan Description 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 Summary Plan Description as **covered expenses** that are **medically necessary**.
- This Summary Plan Description 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 Summary Plan Description in a safe place for future reference.

Common Terms

Many terms throughout this Summary Plan Description are defined in the *Glossary* section at the back of this document. Some of the more important defined terms appear in bolded print. Others are defined within the text of the document where they appear. Understanding these terms will also help you understand how your Plan works and provide you with useful information regarding your coverage.

About Your Plan: The Aetna Choice POS II Coverage Option

This Plan’s Aetna Choice POS II coverage option 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 this option, you can directly access any **network** or **out-of-network physician, hospital** or other health care provider 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** under this Plan.

Important Note

Network providers have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **covered individuals under the Plan**. **Network providers** are generally identified in the printed **directory** and the on-line version of the **directory** via On-line provider directory at www.aetna.com unless otherwise noted in this section. Pharmacy Network providers have contracted with CVS Caremark and the on-line directory is located at www.caremark.com. **Out-of-network providers** are not listed in the **Aetna directory**.

The Plan will pay for **covered expenses** up to the maximum benefits shown in this Summary Plan Description or in the current *Schedule of Benefits*.

Coverage is subject to all the terms, policies and procedures outlined in this Summary Plan Description. 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* sections and *Schedule of Benefits* to determine if medical services are covered, excluded or limited.

This Aetna Choice POS II option provides access to covered benefits through a broad network of health care providers and facilities. The Aetna Choice POS II option is designed to lower your out-of-pocket costs when you use **network providers for covered expenses**. Your **deductibles, copayments, and coinsurance** will generally be lower when you use **network providers** and facilities.

You also have the choice to access licensed **providers, hospitals** and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network providers** because the **deductibles, copayments, and coinsurance** that you are required to pay 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 **paid** under this Plan.

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 is retained by the Plan to conduct ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are **covered expenses** under this Summary Plan Description. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Reporting of Claims* and the *Claims and Appeals* sections of this Summary Plan Description.

To better understand the choices that you have under the Plan's Aetna Choice POS II option, please carefully review the following information.

How the Plan's Aetna Choice POS II Option 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 On-line provider directory, **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. On-line provider directory is updated several times a week. You may also request a printed copy of the provider directory 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**.

Note: The Plan will comply with PPACA restrictions on the designation of a primary care physician. If the Plan requires or provides for designation by a participant or beneficiary of a participating primary care provider or a pediatrician for the participant's child, the Plan shall permit the participant or beneficiary to designate any primary care provider or pediatrician who is available to accept the participant or beneficiary and who is in the Plan's network.

Changing Your PCP

You may change your **PCP** at any time.

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 Summary Plan Description. 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.

Note: The Plan will comply with the PPACA restrictions on preauthorization and referral for OB/GYN Care. The Plan will not require **precertification** or referral by the Plan (or from a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

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**, On-line provider directory, for names and locations of **physicians, hospitals** and **other health care** providers and facilities. You can change your **PCP** at anytime.
- If a service or supply you need is covered under this Plan but not available from a **network provider** in your area, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a **referral** that has been approved by **Aetna**, you will receive the network benefit level as shown in your *Schedule of Benefits*.
- If a service or supply you need is covered under this Plan but not available from a **network provider 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.
- Except for your **prescription drug** expenses, 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. The Plan 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 may be required to pay some **network providers** at the time of service. When you pay a **network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from the Plan. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Summary Plan Description for a complete description of how to file a claim under this Plan.
- 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, 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**. The Plan will reimburse you for a **covered expense not otherwise paid directly to the provider when** incurred from a **network provider**, up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles, copayments and coinsurance**. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the Plan will begin to pay benefits.
- **Deductibles** and **coinsurance** are usually lower when you use **network providers** than when you use **out-of-network providers**.
- For certain types of services and supplies, you will be responsible for any **copayments** shown in your *Schedule of Benefits*. The **copayments** will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a **specialist** or non-**specialist**. You will be subject to the **PCP copayments** shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **network provider**. If the provider is a **network specialist**, then the **specialist copayment** will apply.
- 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 **payment percentage** 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 limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limits**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your Plan.
- The Plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.
- You may be billed for any **deductible, copayment, or coinsurance** amounts, or any non-covered expenses that you incur.

Note: You are not responsible for cost sharing under the Plan with regard to certain preventive services as provided under the PPACA. See the *Preventive Care* section of this Summary Plan Description.

Accessing Out-of-Network Providers and Benefits

- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with **Aetna** to verify coverage for these 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** the services for you. However, you should verify with **Aetna** prior to the service, that the provider has obtained **precertification** from **Aetna**. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, 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 to **Aetna** for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to an **out-of-network provider**.
- When you pay an **out-of-network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Summary Plan Description for a complete description of how to file a claim under this Plan.
- You will receive notification of what the Plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, or **coinsurance** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Important Note

Failure to **precertify** services and supplies, when required, will result in a reduction of benefits or no coverage for the services or supplies under this Summary Plan Description. The Plan will not require pre-authorizations for emergency services, whether in or out of network, where pre-authorization is prohibited by the **PPACA**. Please refer to the *Understanding Precertification* section for information on how to request **precertification**.

Cost Sharing for Out-of-Network Benefits

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

- **Out-of-network providers** have not agreed to accept the **negotiated charge**. The Plan 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 the Plan will pay for a **covered expense** from an **out-of-network provider**. Your **coinsurance** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, the Plan will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the Plan begins to pay benefits.
- **Deductibles** and **coinsurance** are usually higher when you use **out-of-network providers** than when you use **network providers**.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limits** that apply 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 limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your Plan.

- The Plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.

Note: When preventive services are available through in-**network providers**, the Plan (1) is not required to offer those services on an **out-of-network** basis, and (2) may require cost sharing if offered. See your *Schedule of Benefits* for more details.

Note: 2014 PPACA Changes: For Plan Years beginning on or after January 1, 2014, the Plan will comply with the annual maximum out-of-pocket limit (as adjusted) or essential health benefits per PPACA Section 1302(c)(1). The Plan will also comply with the wellness program restrictions added by PPACA Section 1201 (and the corresponding changes to the Public Health Service Act, Section 2705).

Understanding Precertification

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. The Plan also does not require **precertification** of any emergency services, whether in- or **out-of-network**, when **precertification** is prohibited under the **PPACA**.

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 may be reduced, or the Plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

Important Note

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

The Precertification Process

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

You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission or medical services and expenses prior to receiving any of the services or supplies that require **precertification** pursuant to this Summary Plan Description in accordance with the following timelines:

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

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

For an emergency admission :	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission :	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness ; the diagnosis of an illness ; or an injury .
For outpatient non-emergency medical services requiring precertification :	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Note: SPECIAL RULES FOR EMERGENCY SERVICES: The Plan will comply with **PPACA** restrictions for emergency services. If the Plan covers **hospital** emergency department services, it must do so consistent with the following rules:

- The Plan may not require any prior **precertification** determination with respect to emergency services, even if the emergency services are provided on an **out-of-network** basis;
- The Plan may not require that the provider furnishing emergency services be a participating network provider;
- If the emergency services are provided out-of-network, the Plan may not impose any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;
- Out-of-network **co-payments** or **coinsurance** for emergency services cannot exceed the in-network **copayments** or **coinsurance** for emergency services. To the extent permitted by the **PPACA**, the Plan reserves its right to require a beneficiary to pay the excess of the amount the out-of-network provider charges over the amount the Plan is required to pay under formulas set out in the Interim Final Rules (as the same rule may be amended). If the Plan imposes a blanket **deductible** on all out-of-network services, the Plan may require the participant to meet that **deductible** when the participant received emergency services in an out-of-network setting to the extent that the participant has not otherwise met the out-of-network **deductible**; and
- The Plan cannot make any other distinctions between in-network and out-of-network emergency services except as may be permitted under the **PPACA**.

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 that requires **precertification**, **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 Claims and Appeals section included with this Summary Plan Description.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- **Stays** in a **hospital**;
- **Stays** in a **skilled nursing facility**;

- **Stays in a rehabilitation facility;**
- **Stays in a hospice facility;**
- **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;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing.
- Transcranial magnetic stimulation (TMS)

How Failure to Precertify Affects Your Benefits

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

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

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary **precertification** is not obtained.

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

It is important to remember that any additional out-of-pocket expenses incurred because your **precertification** requirement was not met will not count toward your **deductible** or **payment limit** 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

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

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

In Case of a Medical Emergency

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

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

Coverage for Emergency Medical Conditions

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

Important Reminder

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

In Case of an Urgent Condition

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 **physician**, please do so as soon as possible after urgent care is provided. If you need help finding an **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 provided by a **physician** who is a **network provider**.

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

Important Notice

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

Requirements For Coverage

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

1. The service or supply or **prescription drug** must be covered by the Plan. For a service or supply or **prescription drug** to be covered, it must:
 - Be included as a covered expense in this Summary Plan Description;
 - Not be an excluded expense under this Summary Plan Description. Refer to the *Exclusions* sections of this Summary Plan Description for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Summary Plan Description. 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 Summary Plan Description.
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

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

Plan Coverage under the Aetna Choice POS II Option

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.

Note: **ESSENTIAL HEALTH BENEFITS**: The Plan will not impose lifetime or annual limits on **essential health benefits** otherwise covered under the Plan, except as permitted under the **PPACA**.

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;
- Health Resources and Services Administration; and
- American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

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

2. If any diagnostic x-rays, lab, or other tests or procedures are ordered, or given, in connection with any of the *Preventive Care* benefits described below, those 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.

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

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;
- Services and supplies furnished by an **out-of-network provider**.

Preventive Care Immunizations

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

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

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

Limitations

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

Well Woman Preventive Visits

Covered expenses include charges made by your **physician obstetrician, or gynecologist** for:

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

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

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

Limitations:

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

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

Preventive Care Heart Screenings

Eligible health services include the following services and tests when ordered by your physician.

- CT for Calcium Scorings
 - Calcium Scoring with CT of heart without contrast material, with quantitative evaluation of coronary calcium.
- Cardiovascular Stress Test
 - Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress;
 - with physician supervision; with interpretation and report
 - supervision only without interpretation and report
 - tracing only, without interpretation and report
 - interpretation and report only

Limitations:

Unless specified above, not covered under this benefit are:

- Charges incurred for services which are covered to any extent under any other part of this Plan.
- Services and supplies furnished by an **out-of-network provider**.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows when ordered by your physician:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE)
- Colonoscopies (removal of polyps performed during a screening procedure is a covered expense); and
- Lung cancer screening.
- Skin cancer screening.
- Ovarian cancer screening.

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

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

Limitations:

Unless specified above, not covered under this benefit are:

- Charges incurred for services which are covered to any extent under any other part of this Plan.
- Services and supplies furnished by an **out-of-network provider**.

Note: The Plan will comply with all **PPACA** restrictions on preventive care services. The Plan shall incorporate the following rules regarding these services:

- **First Dollar Care.** The Plan shall not enforce any cost sharing provisions (for example, **copays**, **coinsurance** or **deductibles**) with regard to preventive services to the extent prohibited under the **PPACA**.
- **Office Visits.** The Plan shall follow **PPACA** guidance with regard to charges for separately tracked services and billings that include both preventive and other services.
- **Out-of-Network Coverage.** If the Plan has a network of providers to provide the required preventive services and the Plan imposes no cost sharing requirements when the services are provided in-network, then the Plan does not need to provide coverage for preventive services on an out-of-network basis. To the extent the Plan does provide coverage for preventive services delivered by out-of-network providers, the Plan is not prohibited from imposing cost-sharing requirements for preventive services received from **out-of-network providers**.
- **Reasonable Medical Management.** The Plan reserves its right, to the extent not specified or prohibited in a **PPACA** recommendation or guideline, to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service item or service. The Plan will follow federal preventive service guidelines. In the absence of specific guidance, the Plan may fill gaps in the federal preventive service guidelines using reasonable medical management techniques when a federal preventive service guideline does not specifically state how often a preventive service should be provided, the method with which it should be provided, its treatment modality, or where it should be provided.
- **Additional Preventive Services.** To the extent that the Plan provides coverage for preventive services or items that are not included in the list of recommended preventive service items or services, the Plan is not prohibited from imposing cost-sharing requirements on such services and items. The Plan is also not prohibited from imposing cost-sharing requirements with respect to recommended preventive services or items that go beyond the specific recommendation or the Plan's reasonable medical management guidelines for the preventive service or item (if the federal guideline does not specifically identify the frequency, method, treatment or setting for the particular preventive service or item).
- **Future Guidance.** The Plan will update and comply with additional preventive service coverage and restrictions as additional **PPACA** guidance is released.

Important Notes:

Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to Preventive Care. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.

Screening and Counseling Services

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

Obesity and/or Healthy Diet

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- preventive counseling visits and/or risk factor reduction intervention;
- 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.

Misuse of Alcohol and/or Drugs

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

Use of Tobacco Products

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

- preventive counseling visits;
- treatment visits; and
- class visits;
- Tobacco cessation prescription and over-the-counter drugs
 - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

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

Sexually Transmitted Infections

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

Genetic Risks for Breast and Ovarian Cancer

Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

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

Limitations:

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

- Services which are covered to any extent under any other part of this plan;
- Services and supplies furnished by an **out-of-network provider**.

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, fetal heart rate check, and fundal height).

Limitations:

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

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above).

Important Notes:

Refer to the *Pregnancy Expenses* and *Exclusions* sections of this Summary Plan Description for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

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

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. See the current *Schedule of Benefits* for possible limits or visit maximums.

Breast Feeding Durable Medical Equipment

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

Breast Pump

Covered expenses include the following:

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

Breast Pump Supplies

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

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

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

Limitations:

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

Family Planning Services - Female Contraceptives

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. See the current *Schedule of Benefits* for possible limits or visit maximums.

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

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

Important Note:

For a list of the types of female contraceptives covered under this Plan, refer to the section *What the Pharmacy Plan Covers* and the *Contraceptives* benefit later in this Summary Plan Description.

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;
- Services and supplies furnished by an **out-of-network provider**.

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
- Medically necessary termination of pregnancy
- Pregnancy termination as a result of sexual assault

Limitations:

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Non-medically necessary termination of pregnancy except where pregnancy occurs as a result of sexual assault;
- 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:

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

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 12 consecutive month period.

Limitations

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

Hearing Exam

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

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

The Plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

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

Physician Services

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;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
 - to stop the use of tobacco products;
 - in weight reduction due to obesity.

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

- In a group setting for screening and counseling services.

Important Note:

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

E-Visits

Covered expenses include charges made by your **physician** 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 Member website on www.Aetna.com or by calling the number on your identification card.

Hospital Expenses

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

Room and Board

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

Room and board charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

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

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

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

Outpatient Hospital Expenses

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

Important Reminders

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

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

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

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

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

Coverage for Emergency Medical Conditions

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

The **emergency care** benefit covers:

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

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

Important Reminder

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

Coverage for Urgent Conditions

Covered expenses include charges made by a **hospital** or **urgent care 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

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

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

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

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

Covered expenses include only the following:

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

See the current *Schedule of Benefits* for possible limits or visit maximums.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating,

toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

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

Limitations

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

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

Important Reminders

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

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

Skilled Nursing Care

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

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 disability; 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

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

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

Ground Ambulance

Covered expenses include charges for transportation:

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

Air or Water Ambulance

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

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

Limitations

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

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

Autism Spectrum Disorder

Covered expenses include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior 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 child is diagnosed with Autism Spectrum Disorder.

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

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

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Important Reminder

Before you receive treatment, call Aetna Member Services at the number on the back of your I.D. card to ensure that the services will be covered and that an appropriate treatment plan is in place.

Obesity surgery

Eligible health services include obesity surgery, which is also known as “weight loss surgery.” Obesity surgery is a type of procedure performed on people who are **morbidly obese**, for the purpose of losing weight.

Obesity is typically diagnosed based on your **body mass index (BMI)**. To determine whether you qualify for obesity surgery, your doctor will consider your **BMI** and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a **BMI** less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a **network provider** for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam
- Outpatient **prescription drug** benefits included under the *Outpatient prescription drugs* section

Health care services include one obesity surgical procedure. However, **eligible health services** also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

The network level of benefits is paid only for a treatment received at a facility designated by the Plan as an Institutes of Quality® (IOQ) for the type of surgery being performed. Each IOQ facility has been selected to perform only certain types of surgeries.

Services obtained from a facility that is not designated as an IOQ for the surgery being performed will not be covered, even if the facility is a network facility or IOQ for other types of services.

Blood and Blood Products

Covered expenses include charges for the administration of blood and blood products, but not the cost of the blood or blood products.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

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

- C.A.T. scans;
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA);
- 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.

Outpatient Diagnostic Lab Work and Radiological Services

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

Important Reminder

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

Outpatient Preoperative Testing

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

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

Limitations

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

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

Important Reminder

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

Durable Medical and Surgical Equipment (DME)

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

Important Reminder

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

Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)

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

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

An “approved clinical trial” is a clinical trial that meets these criteria:

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

Routine Patient Costs

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

Limitations:

Not covered under this Plan are:

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

Important Note:

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

Pregnancy Related Expenses

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

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

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

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

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

Important Note:

Refer to the *Preventive Care* section of this *Summary Plan Description* for additional information on coverage for female contraceptive coverage under this Plan.

Prosthetic Devices

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

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

The Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet; unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

Hearing Aids

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

See the current Schedule of Benefits for possible limits or maximums.

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

Benefits After Termination of Coverage

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The **prescription** for the hearing aid was written; and
- The hearing aid was ordered.

Short-Term Rehabilitation Services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. **Eligible health services** include short-term rehabilitation services your **physician** prescribes. The services have to be performed by:

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

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute **illness, injury or surgical procedure**.

- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
 - Significantly improve, develop or restore physical functions you lost as a result of an acute **illness, injury or surgical procedure**, or
 - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
 - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute **illness, injury or surgical procedure**, or
 - Improve delays in speech function development caused by a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Limitations

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

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
 - Autism Spectrum Disorder
 - Down syndrome
 - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a **home health care agency**.
- Services provided by a **physician**, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits have been paid under the spinal manipulation section.
- Services not given by a **physician** (or under the direct supervision of a **physician**), physical, occupational or speech therapist.
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age).

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy (except for services provided in an educational or training setting), if it is expected to develop any impaired function.

- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
- Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development.

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

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. See the current *Schedule of Benefits* for possible limits or visit maximums.
- 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. See the current *Schedule of Benefits* for possible limits or visit maximums.

See the current *Schedule of Benefits* for possible limits or visit maximums.

The therapy should follow a specific treatment plan that:

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

Important Reminder

See the current *Schedule of Benefits* for possible limits or visit maximums.

Reconstructive or Cosmetic Surgery and Supplies

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

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

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

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

Reconstructive Breast Surgery

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

Important Notice

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

Specialized Care

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

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

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

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

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

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

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

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

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

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

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Summary Plan Description*.

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

Important Reminder

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

Specialty Care Prescription Drugs

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

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

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

Diabetic Equipment, Supplies and Education

Eligible health services include:

- Services and supplies
 - Foot care to minimize the risk of infection
 - Insulin preparations
 - Diabetic needles and syringes
 - Injection aids for the blind
 - Diabetic test agents
 - Lancets/lancing devices
 - Prescribed oral medications whose primary purpose is to influence blood sugar
 - Alcohol swabs
 - Injectable glucagon
 - Glucagon emergency kits
- Equipment
 - External insulin pumps
 - Blood glucose monitors without special features, unless required due to blindness
- Training
 - Self-management training provided by a health care provider certified in diabetes self-management training

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.

Treatment of Infertility

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**.

Jaw Joint Disorder Treatment

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

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

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a **jaw joint disorder**.

Transplant Services

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

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;

- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the Plan.

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

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

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

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

The Plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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

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

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

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

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

Important Reminders

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

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

Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

Network of Transplant Specialist Facilities

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

Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

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

Important Note

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

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

Inpatient Treatment

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

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

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

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

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

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

Outpatient mental health treatment also includes:

- Electro-convulsive therapy (ECT); and
- Substance use disorder injectables.
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- 23 hour observation
- Peer counseling support by a peer support specialist
 - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a **behavioral health provider**.

Important Reminder

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums, **payment limits** or **maximum out of pocket limits** that may apply to your **mental disorders** benefits.

Treatment of Substance Abuse

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

Important Note

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

Substance Abuse

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles**, maximums and **payment limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Inpatient Treatment

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

Coverage includes:

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

Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Outpatient Treatment

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

- Office visits to a **physician** or **behavioral health provider** such as a **psychiatrist**, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes **telemedicine** consultation)
- Individual, group and family therapies for the treatment of **substance abuse**
- Outpatient detoxification
- **Partial hospitalization treatment** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
- **Intensive outpatient program** provided in a facility or program for treatment of **substance abuse** provided under the direction of a **physician**
- Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other **substance abuse**, including administration of medications
- Treatment of withdrawal symptoms
- 23 hour observation
- Peer counseling support by a peer support specialist
 - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Important Reminder

Inpatient treatment, partial-**hospitalization** care and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

Partial Confinement Treatment

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

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

Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/ deductibles**, maximums, **payment limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

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

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues. Non-surgical treatment of Temporomandibular Joint (TMJ) dysfunction may be limited. See the current *Schedule of Benefits* for possible limits or visit maximums.

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, including implants, 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 Plan Year of the accident or in the next Plan Year. See the current *Schedule of Benefits* for possible limits or visit maximums.

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**.

Gender Dysphoria (sex reassignment) surgery, counseling

Eligible health services includes medically necessary services and supplies for gender dysphoria (sometimes referred to as sex reassignment) surgery.

You must be at least 18 years old to be eligible for this benefit.

Eligible health services include:

- The surgical procedure
- Physician pre-operative and post-operative hospital and office visits
- Inpatient and outpatient services (including outpatient surgery)
- Skilled nursing facility care
- Administration of anesthetics
- Outpatient diagnostic testing, lab work and radiological services
- Blood transfusions and the cost of un-replaced blood and blood products as well as the collection, processing and storage of self-donated blood after the surgery has been scheduled.
- Gender reassignment counseling by a behavioral health provider

- Hormone therapy

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male trans identified persons who have not undergone a mastectomy.
- Prostate cancer screening may be medically necessary for male to female trans identified persons who have retained their prostate.

Your doctor will request approval in advance of your surgery. You may go to any of our **network** facilities that perform sex reassignment surgeries.

Limitations

Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.

Medical Plan Exclusions

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 Summary Plan Description.

Important Note:

You have medical and prescription drug 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 Summary Plan Description for care that is not required in connection with an essential health benefit.

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 Summary Plan Description. This also includes **prescription drugs** or supplies if:

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

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

Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental disability. 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 Summary Plan Description.

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

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

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

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

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

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

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

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

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- 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); except removal of an implant will be covered when **medically necessary**;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the ***What the Plan Covers*** section.

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

Custodial Care

Examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral 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 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. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

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

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

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;

- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Any expenses for prescription drugs, and supplies covered under the CVS Caremark Pharmacy plan will not be covered under this medical Plan. Prescription drug exclusions that apply to the CVS Caremark Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

Examples of those services are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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.

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

Facility charges for care services or supplies provided in:

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

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.

Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

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

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

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except as otherwise provided under the *What the Plan Covers* section.

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

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

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

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;

- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination;
- 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.

Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

Maintenance Care.

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the Eligible health services under your plan – Habilitation therapy services section.

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 or CVS Caremark**, 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.

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

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

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

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

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

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

Services that are not covered under this Summary Plan Description.

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.

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

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

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;

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

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

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 the ***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.

Voluntary termination of pregnancy, including related services.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, except as specifically provided in the *What the Plan Covers* section, including but not limited to:

- Liposuction, surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to weight loss
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Wilderness treatment programs (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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

Gender Dysphoria

Cosmetic Procedures including the following:

Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization.

PRESCRIPTION DRUG BENEFITS

Your benefits under the Plan will differ depending on the type of prescription drug you take (for example, [generic vs. preferred vs. non-preferred vs. specialty]), how you buy it (for example, from a Participating Network Provider vs. non-Participating Network Provider, or at a pharmacy vs. through the mail), and the other cost-savings measures implemented by the Employer.

TYPE OF DRUG

All prescription drugs that are covered under the Plan fit within one of the following categories:

- **Generic:** A non-brand name drug that has the same active ingredients as a brand-name drug and is sold for substantially less than the brand-name drug. For a detailed list of the generic drugs covered under the Plan, you may call CVS Caremark Customer Service at 1-888-202-1654 or visit www.caremark.com. This list is available at no charge.
- **Preferred:** A drug that is on the list of preferred brand name drugs and requires you to pay less than you would pay for a non-preferred drug. Drugs in this category are based on a combination of factors, including safety, effectiveness and cost. For a detailed list of the preferred drugs covered under the Plan, you may call CVS Caremark Customer Service at 1-888-202-1654 or visit www.caremark.com. This list is available at no charge.
- **Non-Preferred:** A drug that is not on the list of preferred brand name drugs and requires you to pay more than you would pay for a preferred drug. For a detailed list of the non-preferred drugs covered under the Plan, you

may call CVS Caremark Customer Service at 1-888-202-1654 or visit www.caremark.com. This list is available at no charge.

- Specialty: Drugs that are used in the management of chronic or genetic diseases, including injectables, infused drugs or oral medications, or drugs that otherwise require special handling. Specialty drugs must be obtained exclusively through the CVS Specialty Pharmacy, or can be dropped off at a local CVS retail pharmacy (See Specialty Connect™). For a detailed list of the specialty drugs covered under the Plan, you may call CVS Specialty at 1-800-237-2767 or visit www.cvspecialty.com. This list is available at no charge.

The category to which a particular drug belongs may change periodically based on CVS Caremark's formulary. These changes may occur without notice to you. When a change occurs, you may be required to pay more or less for a covered prescription drug, depending on the category to which it is assigned. Because a drug's category may change periodically, you should call CVS Caremark Customer Service at 1-888-202-1654 or visit www.caremark.com for the Plan's most current information.

RETAIL PURCHASES

The Plan allows you to fill prescriptions at a retail pharmacy. You should use a retail pharmacy when filling short-term prescriptions for medications such as antibiotics. Through a retail pharmacy, you are generally able to receive up to a 30-day supply of medication.

If you receive your prescription drug from a Participating Network Pharmacy, you should show the pharmacist your ID card at the time you submit your prescription. You will be required to pay the applicable amount at the time of purchase. The Plan will pay the remaining cost of the prescription drug if there is coverage for that prescription drug under the Plan.

If you fill your prescription at a non-Participating Network Pharmacy, or if you fail to show your ID card at the time of purchase from a Participating Network Pharmacy, you may be required to pay the entire cost of the prescription drug at the time of your purchase. The Plan will pay its share of the cost of the drug once you submit a claim form to the Plan's Pharmacy Benefit Manager. You may obtain a claim form from the Plan's Pharmacy Benefit Manager (CVS Caremark) by calling 1-888-202-1654. The claim form will include specific instructions on how and where to file the claim. The claim form must be mailed to the address indicated on the claim form.

MAIL ORDER SERVICE PURCHASES

The Plan allows you to fill certain prescriptions through its mail order service. You should use the Plan's mail order service when filling long-term maintenance medications. Maintenance medications are used to treat chronic illnesses such as heart conditions, allergies, high blood pressure, and arthritis. Through the mail order service, you are generally able to receive up to a 90-day supply of your medication. You should inform your prescribing physician that you have a mail order prescription drug program. That information will indicate to your prescribing physician that you can obtain a 90-day supply of your medication. To obtain a prescription through the Plan's mail order service, you must complete an order form and send it to CVS Caremark along with your prescription and your applicable payment amount. It may take up to 2-3 weeks to receive your prescription in the mail. You may later order refills on your prescription through the mail order service by calling 1-888-202-1654 or by visiting www.caremark.com. This will reduce the time it takes to receive your refill.

PRIOR AUTHORIZATION REQUIREMENT

Certain prescription drugs are subject to prior authorization from the Plan. This means that you must obtain approval through CVS Caremark before your medication will be covered under the Plan. The prior authorization criteria are developed in order to ensure safe, effective and appropriate utilization of selected drugs. Your prescribing physician will be required to confirm that you have met the required evidence-based criteria before the Plan will cover your prescription. You will be informed about any prior authorization requirement that applies to your prescription at the time of your purchase. In addition, you may determine whether a prior authorization will apply to your prescription by contacting CVS Caremark Customer Service at 1-888-202-1654.

MAINTENANCE CHOICE

You have the option of receiving long-term maintenance prescription drugs through the Plan's mail order service described above or at a local CVS retail pharmacy. This program provides you with the flexibility to decide which delivery system is most convenient to you. If you utilize a CVS retail pharmacy, you will have the opportunity to discuss your medication face-to-face with a pharmacist. You will pay the same amount for your 90-day supply of maintenance medication whether you receive it at a local CVS retail pharmacy or through the Plan's mail order service.

DISPENSE AS WRITTEN (DAW)

If you choose to receive a brand name drug when a generic drug is available (such as when the prescription contains a "dispense as written" restriction), you will be responsible for paying the difference between the cost of the brand name drug and the cost of the available generic drug. You will also be responsible for paying the applicable co-insurance amount for your prescription.

SPECIALTY GUIDELINE MANAGEMENT

The Plan has adopted the Specialty Guideline Management program, which evaluates the appropriateness of drug therapy for specialty medications according to evidence-based guidelines both before the initiation of therapy and on an ongoing basis. This program is available for all specialty conditions, and outreach is made to both the Participant and the prescriber to evaluate the therapy.

The Specialty Guideline Management program requires approval of treatment for select medicines. Under this program, there will be a review of clinical information for approval of treatment with these medicines. Decisions are based on nationally recognized guidelines and are administered by a CVS Caremark clinical specialist.

ADVANCED CONTROL SPECIALTY FORMULARY

The Plan has adopted the CVS Caremark Advanced Control Specialty Formulary™ program that acts as a guide to encourage physicians to prescribe drugs that are clinically effective and are available at the lowest net cost without sacrificing treatment outcomes. Under this program, the Pharmacy Benefit Manager may exclude certain products. Generics will be considered the first line of prescribing. If there is no generic available, there may be more than one brand name medicine to treat a condition. The Pharmacy Benefit Manager may contact your doctor after receiving your prescription to request consideration of a drug list product or generic equivalent. This may result in your doctor prescribing, when medically appropriate, a different brand-name product or generic equivalent in place of your original prescription. You may be responsible for the full cost of non-formulary products that are removed from coverage. In most instances, a brand name drug for which a generic product becomes available will be designated as a non-preferred option upon release of the generic product into the marketplace. For specific information regarding your prescription benefit coverage and copayment information, you can visit www.caremark.com or contact CVS Caremark Customer Service at (888) 202-1654.

SPECIALTY CONNECT™

The Plan has adopted the CVS Caremark Specialty Connect™ program. A Participant may take advantage of this program by dropping off or having a specialty prescription sent to any CVS retail pharmacy, or the Participant's doctor may send the prescription to the Plan's specialty mail order service. A Participant may then choose to pick up specialty medications at a CVS retail pharmacy, have them shipped to the Participant's home address, or have them shipped to a location of choice. Additionally, clinical services for Participants taking specialty drugs will be offered through the CVS Caremark CareTeams. The CareTeams are staffed by specialty pharmacy clinicians with up-to-date knowledge on evidence-based protocols. CareTeams will work to help improve Participants' adherence by educating them about taking their medications correctly, reviewing proper medication storage and handling, and troubleshooting medication side effects.

NEW DRUGS

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, the Plan Sponsor will work with CVS Caremark to determine whether a particular new drug will be covered under the Plan and whether any coverage restrictions or limitations will apply.

EXCLUSIONS FROM COVERAGE

Certain expenses that you or your Covered Dependents incur for medications are not covered under the Plan.

For a list of excluded drugs, you may log on to www.caremark.com/druglist or contact CVS Caremark Customer Service at 1-888-202-1654 for more information.

PLEASE NOTE: Effective October 1, 2018, select non-formulary drugs that were previously covered under the Plan will no longer be covered, unless your physician can show that the drug is medically necessary and complies with the Plan's prior authorization process. If medical necessity is demonstrated and the prior authorization is approved, the drug will be covered at a non-preferred coverage tier. Refills of the excluded drug will be covered at a non-preferred coverage tier and prior authorization may need to be renewed periodically.

CLAIMS PROCEDURES

NOTIFICATION OF THE PLAN'S DETERMINATION

Once your claim is submitted to the Plan, the Pharmacy Benefit Manager will make a decision with respect to your claim. If your claim is wholly or partially denied, the Pharmacy Benefit Manager will notify you of that decision in writing which will contain: (i) specific reasons for the claim's denial, (ii) specific reference to relevant Plan provisions, (iii) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if you wish to appeal the Pharmacy Benefit Manager's decision. In addition, you will be notified of any Adverse Benefit Determination that results in a rescission of your coverage. A rescission of coverage refers to a cancellation or discontinuance of coverage that has retroactive effect, but does not include any such cancellation or discontinuance to the extent it results from a failure to pay on a timely basis premiums or contributions towards the cost of Plan coverage. You will also be notified of the steps to be taken if you wish to appeal the Pharmacy Benefit Manager's decision regarding your rescission. In addition to the information above, the notice will also contain any information regarding an internal rule, guideline or protocol that was relied on in making the benefit determination. Also, if the denial is based on medical necessity, experimental treatment or a similar exclusion or limit, the notice will contain an explanation of the scientific or clinical judgment used in the determination. If the notice does not contain such statements or explanations, the notice will contain a statement indicating that this information will be provided to you upon written request at no charge.

TIMING OF NOTIFICATION

Notification regarding your claim will be given within the following timeframes, depending on the type of claim you submitted:

- A. Urgent Care Claims – within 72 hours after receipt of your claim, unless you do not provide enough information for the Pharmacy Benefit Manager to determine whether or to what extent benefits are payable under the Plan. If this occurs, the Pharmacy Benefit Manager will notify you of the deficiency within 24 hours of receiving your claim. You will have a reasonable amount of time, not less than 48 hours, to provide the additional necessary information. The Pharmacy Benefit Manager will notify you of the Plan's determination as soon as possible, but no later than 48 hours after the earlier of (i) the Plan's receipt of the additional information, or (ii) the end of the time period given to you to provide additional information.

An "urgent care claim" is a claim for prescription drugs care or treatment where a delay in making a determination could jeopardize the life or health of you or your Covered Dependent or the ability of you or your Covered Dependent to regain maximum function, or, in the opinion of your physician or your Covered Dependent's physician, would subject you or your Covered Dependent to severe pain that cannot be adequately managed without the requested treatment.

- B. Pre-Service Claims – within a reasonable time, but no longer than 15 days after receipt of your claim. An extension of an additional 15 days may be granted due to matters beyond the control of the Pharmacy Benefit Manager, but only if the Pharmacy Benefit Manager notifies you before the end of the first 15 days of the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A “pre-service claim” is a request for approval of a prescription drug where receipt of the prescription drug is conditioned, in whole or in part, on approval in advance of obtaining the prescription drug. Examples include pre-authorizations for certain prescription drugs.

- C. Post-Service Claims – within a reasonable time, but no later than 30 days after receipt of your claim. The review period may be extended for 15 days due to matters beyond the Pharmacy Benefit Manager's control if the Pharmacy Benefit Manager notifies you of the extension before the end of the first 30-day period, the circumstances requiring the extension and the date by which the Pharmacy Benefit Manager expects to make a decision. If the extension is due to your failure to submit necessary information, the extension notice will describe the additional necessary information, and the time period for deciding your claim will be suspended until the earlier of (i) the day you respond to the notice, or (ii) at least 45 days from receipt of the notice requesting additional information.

A “post-service claim” is any claim for prescription drug benefits that is not a pre-service claim or an urgent claim.

- D. Ongoing Treatment – if you are receiving ongoing treatments (*i.e.*, treatment over a period of time or a specified number of treatments) that have been previously approved by the Plan, any reduction or termination of ongoing treatments is an Adverse Benefit Determination. The Pharmacy Benefit Manager must notify you within a reasonable time prior to the reduction or termination of services.
- E. Care Outside the United States - Prescription drugs purchased outside of the United States are generally not covered under the Plan. However, if you are outside of the United States and need to purchase prescription drugs due to an emergency, such medication will be covered as if you had received it from a Participating Network Pharmacy. In such circumstances, you will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a claim form to CVS Caremark for reimbursement from the Plan.
- F. Non-Participating Providers - If you use a pharmacy that is not a Participating Network Pharmacy, or if you do not have your Plan ID card at the time of your purchase at a Participating Network Pharmacy, you may be required to pay for the entire cost of the prescription drug at the time of purchase. In that case, you may file a claim to recover from the Plan the amount payable by the Plan (if any) in connection with your prescription drug purchase.

PROVIDER NETWORK

PARTICIPATING NETWORK PHARMACIES

The Plan provides you with access to an extensive national pharmacy network. The Plan has entered into contractual arrangements with various pharmacies throughout the country called “Participating Network Pharmacies.” These Participating Network Pharmacies generally offer Participants access to prescription drugs at discounted rates in exchange for being able to participate in the network. Generally, Participating Network Pharmacies are available to help Participants with their short-term medications. (Participants will also have access to a mail order service for long-term or maintenance medications.) Participating Network Pharmacies are not limited to CVS retail stores. You will be furnished with a list of Participating Network Pharmacies as a separate document, automatically and without charge. To find a Participating Network Pharmacy, you may also log on to www.caremark.com or contact CVS Caremark Customer Service at 1-888-202-1654.

Participants may also use other pharmacies (pharmacies that are not Participating Network Pharmacies). However, the cost of prescriptions drugs from such a pharmacy may be higher.

INTERNAL APPEAL PROCEDURES

If your claim is denied and you wish to have the claim reconsidered, you, or your authorized representative on your behalf, may appeal the denial and request a review of your claim. Your appeal must be received by the Pharmacy Benefit Manager within 180 days after your receipt of the notice of denial.

When you submit your appeal, you may also submit additional comments, records and documents related to your claim. You may also, upon request and at no charge, review copies of the documents and information relevant to your claim.

Appeals should include the following information:

- name of the Participant who is the subject of the appeal;
- the Participant’s CVS Caremark ID number;
- the Participant’s date of birth
- a written statement of the issue(s) being appealed;
- name of the drug(s) being requested; and
- written comments, documents, records or other information relating to the claim being appealed.

Your appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax Number for Appeals: (866) 443-1172

Note that the Plan provides for an expedited review process with respect to urgent care claims. You may request an expedited appeal of an Adverse Benefit Determination orally or in writing. The expedited process allows you to transmit and receive information from the Plan by telephone, facsimile or other similar expedited means. Physicians may submit urgent appeal requests by calling the physician-only toll-free number at (866) 443-1183.

NOTIFICATION OF THE PLAN'S DETERMINATION; TIMING

If your appeal is received by the appropriate deadline, the Pharmacy Benefit Manager will independently review your appeal and any additional information that you submit. The Pharmacy Benefit Manager will notify you of its decision regarding your appeal within the following timeframes:

- A. Urgent Care Claims – as soon as possible, but no later than 72 hours after receipt of your appeal.
- B. Pre-Service Claims – within a reasonable period, but no later than 30 days after receipt of your appeal.
- C. Post-Service Claims – within a reasonable period, but no later than 60 days after receipt of your appeal.

With respect to any appeal that is based in whole or in part on a medical judgment, including determinations with respect to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Pharmacy Benefit Manager delegates its fiduciary decision-making authority to one of its outside vendors. In rendering its decision on Plan coverage, the outside vendor, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Pharmacy Benefit Manager will identify the medical or other experts who provided advice to the Plan with respect to your claim. The Pharmacy Benefit Manager currently uses the following vendors for such appeals: Medical Review Institute, MES Solutions, National Medical Review, and Managing Care Managing Costs. However, the outside vendors used by the Pharmacy Benefit Manager may change from time to time.

If your appeal is denied, the Pharmacy Benefit Manager will send you a statement containing: (i) specific reasons for the denial, (ii) specific references to relevant Plan provisions, (iii) a statement that you may have access to or receive, upon request and at no charge, copies of all documents, records and information relevant to your claim, and (iv) a statement describing your right to bring an action in federal court under Section 502(a) of ERISA. In addition to the information above, the notice will contain any information regarding an internal rule, guideline or protocol used in making the appeal decision and an explanation of the scientific or clinical judgment used in the denial. If the appeal notice does not contain such statements or information, the notice will contain a statement indicating that this information is available upon written request and at no charge. If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination. If the appeal notice does not contain such explanation, it will contain a statement indicating that this explanation is available upon written request and at no charge.

The Pharmacy Benefit Manager will provide to you, free of charge, any new or additional evidence or any new or additional rationale, that is considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim. In order to give you an opportunity to respond to such new or additional evidence or the new or additional rationale, this evidence or rationale will be provided to you in advance of the date on which you are to receive a decision on your appeal (as described above). You may review your claim file and present evidence and testimony relevant to your claim.

You must exhaust your rights to appeal under the terms of the Plan before you may bring an action in federal court.

EXTERNAL APPEAL PROCEDURES

POSSIBLE RIGHT TO EXTERNAL APPEAL

If your appeal is denied, you may pursue an external review of your claim by an independent, third party if your claim denial involved either medical judgment (such as a denial based on medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination that the treatment is experimental or investigational) or a rescission of coverage.

STANDARD EXTERNAL REVIEW

If you wish to pursue an external appeal, you must file a request for an external appeal within four months of the date your appeal was denied.

The request for an external appeal should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

The request for an external appeal and supporting documentation may be mailed or faxed to the Pharmacy Benefit Manager as follows:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-3092
Fax Number: (866) 689-3092

Within five days after its receipt of a request for an external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an independent review organization ("IRO"), together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include such information with the request for an external appeal.

Except in the case of an expedited external appeal, as described below, the assigned IRO will provide you and the Plan with written notice of its decision on your external appeal within 45 days of its receipt of your request. If the IRO needs additional information to make a decision, this time period may be extended as permitted by law. The IRO's notice to you shall also include such other information as required by applicable law.

EXPEDITED EXTERNAL APPEAL

The external appeal process will be expedited if you meet the criteria for an expedited external appeal, as defined by applicable law. For example, if you have received an Adverse Benefit Determination that involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, you may expedite your external appeal as well. Similarly, if you have received a final denial of your claim under the internal appeal procedures and you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, or your claim involved an admission, availability of care, continued stay, or a prescription drug benefit for which you received emergency treatment, but have not been discharged from a facility, you may expedite your external appeal.

You or your physician may request an expedited external appeal by calling the Customer Care number on your Plan ID card. The request should include:

- the Participant's name,
- contact information including mailing address and daytime telephone number,
- the Participant's ID number, and
- a copy of the prior appeal denial.

Alternatively, a request for an expedited external appeal and the supporting documentation may be faxed to the Pharmacy Benefit Manager at:

CVS Caremark
External Review Appeals Department
Fax number: (866) 443-1172

All requests for an expedited external appeal must be clearly identified as "urgent" at the time of submission.

Immediately upon its receipt of a request for an expedited external appeal, the Pharmacy Benefit Manager will confirm whether your request is complete and eligible for an external appeal. If the request is complete and eligible for an external appeal, the Pharmacy Benefit Manager will forward the request to an IRO, together with all relevant medical records, all other documents relied upon by the Pharmacy Benefit Manager in making a decision on the case, and all other information or evidence that you or your physician has already submitted to the Pharmacy Benefit Manager. If there is any information or evidence you or your

physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an external appeal.

The assigned IRO will provide you and the Plan with notice of its decision on your external appeal as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for an expedited external appeal. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and the Plan with written confirmation of its decision. The IRO's notice shall also include such other information as required by applicable law.

FINAL DECISION OF IRO

If the final independent decision of the IRO is to approve payment/coverage of the benefit that was previously denied, the Plan will accept the decision and provide coverage for your prescription drug in accordance with the terms and conditions of the Plan. If the final independent decision of the IRO is that payment/coverage will not be made or provided, the Plan will not be obligated to provide coverage for the prescription drug.

Please contact the Plan Administrator or the Pharmacy Benefit Manager for more information on filing an external appeal.

COORDINATION OF BENEFITS

Certain types of plans coordinate the payment of benefits. Benefits paid by the Plan will be coordinated with benefits payable under other plans, including:

- plans provided by an employer, union, trust or similar plan;
- other group health plans that cover you or your dependents; and
- governmental programs or coverage required by law (i.e., Medicare and no-fault automobile insurance).

If you are covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then, based on what the primary plan pays, the other plans may pay a benefit (if any). When benefits are coordinated, the plans decide which plan pays first (i.e., primary), which pays second (i.e., secondary), etc. Below are the guidelines the Plan uses to determine which plan is primary.

- If a plan has no coordination-of-benefits provision, coordinates benefits according to different rules, is a plan required by law (i.e., Workers' Compensation) or a no-fault motor vehicle insurance or third party liability policy, it is primary.
- The plan covering the person as an employee, rather than as a dependent, is primary and pays benefits first. The plan covering an active employee pays first before the plan covering a laid-off or retired employee.
- If both parents' plans cover a dependent, the plans use the birthday rule to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan does not follow the birthday rule, then the rules of that plan determine the order of benefits. If the other plan uses the gender rule, the father's plan is primary.
- In the case of a divorce or separation, the plan of the parent (who has not remarried) with custody of the dependent child usually pays benefits first. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.
- If the parent with custody remarries, his/her plan pays benefits first, the stepparent's plan pays second, and the plan of the parent without custody pays third. However, if there is a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.

If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

LEGAL ACTION

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan shall first exhaust all claim and appeal procedures provided by the Plan, as described above. Any legal action by a person claiming Plan benefits or seeking redress relating to the Plan must be filed within 24 months of the date the eligible charge/claim was incurred.

When Coverage Ends

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

When Coverage Ends for Employees

Your health benefits coverage will end if:

- The health benefits Plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your Employer; or
- Your employment ends.

It is your Employer's responsibility to let **Aetna and CVS Caremark** know when your employment ends.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your Employer is required to give you a certificate of **creditable coverage** when your employment ends. This certificate proves that you were covered under this Plan when you were employed. Ask your Employer about the certificate of **creditable coverage**.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees. (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 addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this Plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

Continuation of Coverage

Continuing Health Care Benefits

Dependent Children with a Disability

Health Expense Coverage for your dependent child with a qualifying disability may be continued past the maximum age for a dependent child. This section applies only to individuals with coverage at the time of disability and not to individuals who have been issued an individual medical conversion policy.

Your child has a qualifying disability if:

- he or she is not able to earn his or her own living because of mental or physical disability 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 qualifying disability.
- Failure to give proof that the qualifying disability 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.

The Plan will have the right to require proof of the continuation of a qualifying disability. The Plan also has the right to examine your child as often as needed while the disability continues at its own expense, provided that 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.

COBRA Continuation of Coverage

Pima County is not subject to the “COBRA” continuation coverage requirements under ERISA, which apply to private sector plans. However, state and local governmental plans, including those established by Pima County, are subject to “COBRA” continuation requirements under the Public Health Services Act, 42 U.S.C. Sections 300bb-1 through 300bb-8. Under the Plan’s COBRA feature, you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions. 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’s third party COBRA administrator 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 notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the Plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former Employer files for bankruptcy	You and your dependents	18 months

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your COBRA administrator within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the COBRA administrator 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 contributions 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 Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the Plan costs.
- During the 18 through 29 month period, contributions 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 contributions 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 contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this Plan may remain in effect until the preexisting clause ceases to apply or the maximum continuation period is reached under this Plan.
- The date your Employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

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

When Coordination of Benefits Applies

Getting Started - Important Terms

Which Pays First

How Coordination of Benefits Works

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This Plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the plans provides coverage for a private room.
2. If a person is covered by 2 or more plans that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with the plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all plans covering a person are high deductible plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one plan that computes its benefit payments on the basis of reasonable or **recognized charges** and another plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether this Plan is a primary plan or secondary plan as to another plan covering the person.

When this Plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, this Plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Which Plan Pays First

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one **plan** is:
 - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - i. The parents are married or living together whether or not married;
 - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the **custodial parent**;
 - The plan of the spouse of the **custodial parent**;
 - The plan of the **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, 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

In determining the amount to be paid when this Plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this Plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this Plan, the amount normally reimbursed for covered benefits or expenses under this Plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this Plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this Plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

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

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, this Plan 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. The Plan 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 this Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

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

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

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease
- Not covered under it because you:
 1. Refused it;
 2. Dropped it; or
 3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

Notwithstanding the previous paragraph, the Plan will continue to pay primary to Medicare for Spouses who are eligible for Medicare due to age.

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 under this Plan.

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 percent of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **Plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **this Plan** and other **plans**. The Plan has authorized **Aetna** to obtain or release any information, and make or recover any payments it considers necessary on behalf of the Plan, in order to administer this provision.

General Provisions

Type of Coverage

Coverage under the Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The Plan covers charges made for services and supplies only while the person is covered under the Plan. The Plan is a self-insurance program; benefits are not paid through individual or group insurance policies.

Physical Examinations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

Governing Law/Governmental Plan

The Plan is a governmental plan within the meaning of Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA). As such, the Plan is not subject to ERISA or to any of the corresponding federal law requirements that apply only to ERISA private sector plans. Notwithstanding anything herein to the contrary, Pima County's adoption of policies and procedures that may mirror or parallel any provision of ERISA, COBRA, USERRA, FMLA, or similar Acts shall not be deemed a waiver of any exemptions that the Employer or the Plan may be entitled to at law or in equity.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims or, if shorter, the applicable statute of limitations under Arizona law.

Additional Provisions

The following additional provisions apply to your coverage:

- This Summary Plan Description 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 the Plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the Plan. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your Employer, **Aetna, or CVS Caremark**.
- Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis.
- The Plan may be changed or discontinued with respect to your coverage.

Financial Sanctions Exclusions

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

Assignments

Coverage and your rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Misstatements

Failure to implement or insist upon compliance with any provision of this Plan at any given time or times, shall not constitute a waiver of any right to implement or insist upon compliance with that provision at any other time or times.

Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this Plan.

Pre-Tax Premium Payments – Section 125

Pima County has established a “cafeteria plan” under Internal Revenue Code Section 125 which allows employees to pay for certain welfare benefits on a pre-tax basis. Pre-tax premiums are subject to restrictions against mid-year changes. Contact your Employer or plan representative for additional information about how the pre-tax premium benefit works.

Rescission of Coverage

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

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

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

For these purposes, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation of coverage on a prospective basis is not a rescission. The Plan shall not cancel coverage retroactively if you fail to timely pay your required contributions toward the cost of coverage.

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

Subrogation and Right of Recovery Provision

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an **injury, illness** or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an **injury, illness** or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an **injury, illness** or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that **injury, illness** or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an **injury, illness** or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the **illness, injury** or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any **illness, injury** or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from *any and all* settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your **injury, illness** or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the **injury, illness** or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/ her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq.*, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation/A.R.S. Section 12-962

The foregoing subrogation and reimbursement rights shall be construed to provide the maximum Plan recovery rights afforded under Arizona Revised Statutes (A.R.S.) Section 12-962.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Workers' Compensation

If benefits are paid under the medical benefits Plan and **Aetna** determines you received Workers' Compensation benefits for the same incident, the Plan has the right to recover as described under the *Subrogation and Right of Reimbursement* provision. **Aetna**, on behalf of the Plan, 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 medical benefits Plan, you will notify **Aetna** of any Workers' Compensation claim you make, and that you agree to reimburse **Aetna**, on behalf of the Plan, as described above.

If benefits are paid under this medical benefits Plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, **Aetna**, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan 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 the Plan may have with respect to such overpayment.

Effective January 1, 2019, the following changes have been made to your Booklet, and are applicable to services received on or after January 1, 2019. The language in the section entitled Recovery of overpayments has been enhanced as follows:

Recovery of overpayments If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces

future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. Prescription claims must be submitted to CVS Caremark. 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.

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.

Discount Programs

Discount Arrangements

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

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

Incentives

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

Discretionary Authority

In carrying out their respective responsibilities under the Plan, the Employer and the claims administrator and other individuals to whom responsibility for administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Except as required for compliance with the PPACA rules regarding claims that are deemed to be exhausted for failure of the Plan to provide a proper internal review, any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious or an abuse of discretion.

Claims, Appeals and External Review

Construction and Future Guidance

The Plan's internal and external review procedures shall be construed for compliance with the **PPACA** claim procedures applicable to an ERISA-exempt governmental plan. Pending additional guidance under the **PPACA**, the following procedures shall be construed in accordance with the Interim Final Rule relating to internal claims and appeals and external review processes under the **PPACA**, dated July 23, 2010, as amended June 24, 2011, and corrected July 26, 2011, as well as Technical Release Nos. 2010-01, 2010-02, 2011-01, and 2011-02, to the extent applicable to state and local governmental plans. The procedures shall be automatically updated by incorporation of any additional guidance for state and local governmental plans. The Employer reserves the right to supplement these procedures by way of separate notices of claim procedures.

Filing Health Claims under the Plan

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

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

Urgent Care Claims

An “Urgent Care Claim” is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

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

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

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

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

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

Ongoing Course of Treatment

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

Health Claims – Standard Appeals

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

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

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including Plan limitations or exclusions;

- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

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

Exhaustion of Internal Appeals Process

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

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna’s or the Plan’s or its designee’s control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

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

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

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

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

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

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

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

“External Review” is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A “Final External Review Decision” is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

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

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

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

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

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

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

and associations;

- (vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- (vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

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

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

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

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

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

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Summary Plan Description.

A

ACA or PPACA

The Patient Protection and Affordable Care Act of 2010.

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Average Wholesale Price (AWP)

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

B

Behavioral Health Provider/Practitioner

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

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 **CVS Caremark** 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 the “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 Summary Plan Description.

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

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 contractholder will give you a copy of this **directory**. **Network provider** information is also available through **Aetna's** online provider **directory**, DocFind®.

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

E-visit

An **E-visit** is an online internet consultation between a **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.

Essential Health Benefits

Essential Health Benefits shall include emergency, hospitalization, maternity and newborn, mental health, substance abuse treatment, preventive and wellness, chronic disease management, and pediatric services including dental and vision, but only to the extent required by the PPACA as the same may be clarified in regulations thereunder.

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.

G

Gender Dysphoria

Means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
 - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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 **CVS Caremark** or consort.

H

Homebound

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
 - **Skilled nursing services**;
 - Medical social services; and
 - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
 - **Physician** services;
 - Physical and occupational therapy;
 - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
 - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
 - One **physician**;
 - One **R.N.**; and

- One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program

This is a written plan of **hospice care**, which:

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

Hospice Facility

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

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

Hospital

An institution that:

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

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

Hospitalization

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

I

Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility

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

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

Injury

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

Institute of Excellence (IOE)

A **hospital** or other facility that has contracted with **Aetna** to give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

J

Jaw Joint Disorder

This is:

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

L

Late Enrollee

This is an employee in an Eligible Class who requests enrollment under this Plan after the Initial Enrollment Period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the Initial Enrollment Period, but for whom coverage is elected at a later time.

However, an eligible employee or dependent may not be considered a **Late Enrollee** under certain circumstances. See the *Special Enrollment Periods* section of the Summary Plan Description.

L.P.N.

A licensed practical or vocational nurse.

M

Mail Order Pharmacy

An establishment where **prescription drugs** are legally given out by mail or other carrier.

Maintenance Care

Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit

Your plan has a **maximum out-of-pocket limit**. Your **deductibles, coinsurance, copays** and other eligible out-of-pocket expense apply to the **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the **Plan Year**. You have a separate **maximum out-of-pocket limit** for network and out-of-network out-of-pocket expenses.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
 - an **illness**;
 - an **injury**;
 - a disease; or
 - its symptoms.

The provision of the service, supply or **prescription drug** must be:

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

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

Mental Disorder

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

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

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

Also included is any other mental condition which requires **Medically Necessary** treatment.

Morbid Obesity

This means a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or Type 2 diabetes mellitus.

N

Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount **CVS Caremark** has established for each **prescription drug** obtained from a **network pharmacy** under this Plan. This **negotiated charge** may reflect amounts **CVS Caremark** 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 **CVS Caremark**.

The **negotiated charge** does not include or reflect any amount **CVS Caremark**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **CVS Caremark**, 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, **CVS Caremark** 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 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.

A **pharmacy** who has contracted to furnish services or supplies for this Plan; but only if the provider is, with **CVS Caremark'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**.

O

Occupational Injury or Occupational Illness

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

Occurrence

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

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

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

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

Out-of-Network Provider

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

A **pharmacy** provider who has not contracted with **CVS Caremark**, an affiliate, or a third party vendor, to furnish services or supplies for this Plan.

P

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.

Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

PPACA or ACA

The Patient Protection and Affordable Care Act of 2010.

Precertification or Precertify

A process where **Aetna** or **CVS Caremark** 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 **CVS Caremark** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **CVS Caremark** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **CVS Caremark** website at www.caremark.com.

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 **CVS Caremark**.

Preferred Network Pharmacy

A **network retail pharmacy** that has contracted with **CVS Caremark**, 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. Covered injectable drugs include injectable insulin.

Preventive Service

Preventive Services for purposes of PPACA compliance shall mean preventive services as defined in regulations and federal recommended preventive service guidelines issued under the **PPACA**. A description of current preventive services shall be made available by the Plan or Aetna.

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 alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**

- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a **physician** who:

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

Q

Qualifying Disability

Your child has a qualifying disability if:

- He or she is not able to earn his or her own living because of mental or physical disability 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.

R

Recognized Charge

The amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The **recognized charge** depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	110% of the Medicare allowable rate
Services of hospitals and other facilities	110% of the Medicare allowable rate
Prescription drugs	
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Recognized charge does not apply to involuntary services.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP **provider**. NAP **providers** are **out-of-network providers** and third party vendors that have contracts with us but are not **network providers**. Except for involuntary services, when you get care from a NAP **provider** your out-of-network cost sharing applies.

Special terms used

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
 - Performed at a network facility by an **out-of-network provider**, unless that **out-of-network provider** is an assistant surgeon for your **surgery**
 - Not available from a **network provider**
 - **Emergency** services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**.

- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
 - The method CMS uses to set Medicare rates
 - What other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable for a particular service or supply

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to **hospitals** or other **providers**. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For **DME**, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than **prescription drug** benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits

We have online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna's member website. Aetna's secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness** or **injury**.

Residential Treatment Facility (Mental Disorders)

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

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

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

Residential Treatment Facility (Substance Abuse)

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

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

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

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

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R.N.** is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

R.N.

A registered nurse.

Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Drug(s)

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

This is the geographic area, as determined by **CVS Caremark**, in which pharmacy **network providers** for this plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
 - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders**.
- Charges patients for its services.

- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of **Hospitals** of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

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

Skilled nursing facility does not include:

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

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care

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

Specialty Care Drugs

Injectable, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.

You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your CVS Caremark secure member website at www.caremark.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 **CVS Caremark** 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 **CVS Caremark** website at www.Caremark.com

Substance Abuse

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

Surgery Center

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - **Physicians** who practice surgery in an area **hospital**; and
 - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Telemedicine

A consultation between you and a provider who is performing a clinical medical or behavioral health service. Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls , except for behavioral health services
- Any other method required by state law

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class

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

U

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.

W

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;**
- The administration of certain immunizations; and
- Individual screening and counseling services.

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.**

IMPORTANT HEALTH CARE REFORM INFORMATION

Guidance continues to be issued under the PPACA and some guidance that has been issued has been issued in a temporary or proposed form or through informal “FAQs” appearing on federal agency websites. The Employer reserves the right to update this Plan for PPACA compliance and to take into account new guidance under the PPACA at any time. This Plan shall be deemed to incorporate any such PPACA guidance as it is effective and Plan representatives are authorized and directed to follow all mandatory PPACA rules to the extent of a conflict herein.

FEDERAL LAW HEALTH PLAN NOTICES

The following notices are intended to provide you with general explanations of certain key federal benefits laws that may impact your rights under the Plan. Some of these notices are updated and distributed on a periodic basis. Contact your Employer or plan representative for up to date notices or if you believe you have not received a notice you are entitled to. When replaced, the most recent notices distributed by the Plan shall control.

Newborns' and Mothers' Health Protection Act (NMHPA)

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 a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Contact your Employer or plan representative for more information.

Women's Health and Cancer Rights Act (WHCRA)

The Plan provides benefits consistent with the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Plan includes coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending **physician** and the patient:

- (1) 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) breast prostheses, and
- (4) physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided subject to the same **deductibles** and **coinsurance** applicable to other similar medical and surgical benefits provided under the Plan. (See the Plan benefits section above or contact your Employer or plan representative for additional details on current **deductibles**, **coinsurance**, and other coverage limitations and requirements.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage under the Plan, some states have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their Employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that participates in the CHIP program, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you and your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Plan, the Plan will permit you to enroll in the Plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

For an updated list of States that participate in the CHIP program, contact the Plan Administrator or the Department of Labor at the following:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Notice of Medicare Part D Rights (Prescription Drug Plans for Medicare Eligible Participants)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. As of the date of this summary, it has been determined that the prescription drug coverage offered by the Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered "Creditable Coverage." Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from October 15 through December 7.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. However, the Plan may coordinate benefits to the extent permitted at law (which determines what program pays first).

If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will not be able to get the Plan coverage back until an annual open enrollment period during which you may re-enroll onto the Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

For more information about this Notice or your current prescription drug coverage, contact the Plan Administrator.

NOTE: You will receive an updated notice separate from this Plan Summary each year. If you do not receive an updated notice, please contact the Plan Administrator. You may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Family and Medical Leave Act (FMLA)

During Family Medical Leave Act (FMLA) leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

The Plan provides benefit protections called for by the FMLA. If a covered employee ceases active employment due to an employer-approved leave in accordance with the requirements of FMLA, coverage will be continued under the same terms and conditions that would have applied had the employee continued in active employment. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification).

See your Employer or plan representative for current eligibility and limitations with regard to your FMLA rights regarding benefits under the Plan.

Pregnancy Discrimination Act

The Plan follows rules under the Pregnancy Discrimination Act designed to provide coverage for pregnancy expenses in the same manner as any other sickness. This requirement applies to pregnancy expenses of an employee or a covered dependent spouse of an employee.

HIPAA Non-Discrimination Notice

The Plan complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prohibit certain discrimination due to health factors of an individual or a dependent of that individual. For instance, a Plan is prohibited from containing an “actively-at-work” requirement that is based on a health factor of an employee. An exception is made with regard to an employee’s first day of work (e.g., if an individual does not report to work on his/her first scheduled work day he/she need not be covered and any waiting period for coverage need not begin). Similarly, a dependent cannot be refused enrollment or coverage based on a “health factor” such as confinement in a health care facility.

Any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual Plan participants or beneficiaries based on any health factor of the participants or beneficiaries. Similarly, any amendment limiting benefits under a Plan based on a health factor must be universally applicable to all individuals. A Plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the Plan and made effective no earlier than the first day of the first Plan year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

An individual who enrolls in accordance with HIPAA’s “Special Enrollment Rights” will not be treated as a “late enrollee” as that term may apply to any pre-existing condition limitations of the Plan or a Component Benefit. Special enrollment rights may apply, for example, when an individual was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him/her and that other coverage was the reason for declining enrollment. HIPAA provides special enrollment rights for other situations, limits the extent to which pre-existing conditions may apply to you or your dependents, and requires the Plan to comply with certain privacy rules. See your Employer or plan representative for detailed HIPAA notices summarizing all of your rights under HIPAA.

HIPAA Privacy Rules & Security Standards

The Plan follows rules designed to ensure privacy over protected health information. In particular, the Plan will follow: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and (2) the HIPAA Security Standards with respect to electronic Protected Health Information, as amended and updated from time to time.

The Plan and Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

NOTE: The Privacy Rule requirements do not apply to “summary health information” that is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. “Summary health information” is health-related information that summarized claims history, claims expenses, or type of claims experienced by individuals, but is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

HIPAA: Notice of Privacy Practices (effective as of September 23, 2013)

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

Introduction

Because we consider your health information to be confidential, we protect the privacy of it in accordance with applicable federal privacy laws. This notice describes how we may use and disclose information about you and explains your legal rights regarding the information.

When we use the term “PHI,” we mean “protected health information,” which is information that identifies you as an individual, such as your name and Social Security number, that relates to your past, present, or future health or healthcare, and that is created or received by a health care provider, health plan, a data clearinghouse, health authority, employer, or school or university.

How We Use and Disclose Protected Health Information

We may use or disclose your protected health information in the following instances, without your prior written authorization:

- **Treatment:** We may use or disclose your PHI to doctors, dentists, pharmacies, hospitals, and other health care providers involved in your treatment. For example, we may release your PHI to doctors who are responsible for your health care in order to supplement or complete their records.
- **Payment:** We may use or disclose your PHI to collect your premium and help pay for your covered services. For example, we may use or disclose your PHI to determine eligibility; determine whether a treatment is experimental or investigational; pay claims; collect premiums; coordinate benefits with other payors; calculate cost-sharing amounts; and respond to complaints, appeals, and requests for external review.
- **Health Care Operations:** We may use or disclose your PHI for our health care operations. For example, health care operations may include (but are not limited to): case management; preventive health and disease management; care coordination; quality and performance assessment and improvement; health services research; and business management and planning, including auditing, licensing, accreditation by independent organizations, and legal or administrative services. Some health care operations may involve underwriting, premium rating, submitting claims, placing a contract for reinsurance of risk relating to claims for health care, including stop-loss and excess loss insurance.

In addition to the above, we may use or disclose your PHI without your written authorization for any of the following purposes (as permitted by law):

- **Plan Administration** – to a plan sponsor or employer (for group health insurance plans) when we have been informed that appropriate language has been included in its plan documents to prevent unnecessary and further disclosures of your PHI, or to assist in obtaining bids from health plans or amending a group health plan.
- **Other Entities** – to other covered entities, business associates, or business associates of other covered entities for purposes related to treatment, payment, and certain health care operations.

- Underwriting – to obtain premium bids for the health insurance coverage offered under your Plan or to decide whether to modify, amend, or terminate certain coverage. In the event we use or disclose your PHI for underwriting purposes, we are expressly prohibited from using or disclosing any health information that contains your genetic information.
- Fundraising – in connection with our fundraising activities, if any, as permitted by law. You have the right to opt out of receiving fundraising communications from us or our business associates.
- Persons Involved in Your Health Care – to a relative, a friend, or any other person you identify provided the information disclosed is directly relevant to that person’s involvement with your health care or payment for that care.
- Research – to researchers provided measures are taken to protect your privacy.
- Industry Regulation – to state insurance departments, boards of pharmacy, the U.S. Food and Drug Administration, U.S. Department of Labor, and other government agencies that may regulate us.
- Law Enforcement and Proceedings – to federal, state, and local law enforcement officials, other legal representatives, and correctional institutions, if applicable, in response to a court order, subpoena, warrant, summons or similar process, or for military, national security and intelligence activities, or for protective services of the President or others.
- Public Health and Welfare – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).
- Workers’ Compensation – to any employer, as needed and permitted by law, provided the PHI relates to a work-related illness or injury or to a workplace-related medical surveillance. We may be required to notify you if we disclose your PHI for this purpose.
- Identification and Location – to appropriate law enforcement and medical officials to identify or locate you to the extent permitted by law. We are prohibited from disclosing certain PHI for this purpose (e.g. DNA, dental records, body fluids/tissue samples or types).
- Decedents – to a coroner or medical examiner to identify you or the cause of your death, or to a funeral director to carry out his/her duties, provided such activities are authorized by law.

Uses and Disclosures Requiring Your Written Authorization

Except in the situations described above, or as required or permitted by law, we must obtain your written authorization before using or disclosing your PHI. For example, we must receive your written authorization in most circumstances that involve:

- Psychotherapy notes in our possession, except as required otherwise by law or in limited circumstances that involve treatment, payment, or health care operations;
- Marketing that is unrelated to your Plan benefits; and
- Selling of your PHI.

If you have given us an authorization and we have not already act on it, you may revoke your authorization at any time. Your revocation will not affect any use or disclosure that was permitted by your authorization while it was in effect or any use or disclosure that is required by law.

Your Legal Rights

- You have the right to ask us to restrict how we use or disclose your PHI in connection with health care operations, payment, and treatment. In most instances, we will consider but are not required to agree to such requests. We will generally honor your request to restrict a disclosure if both (1) the disclosure sought to be restricted is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (2) the PHI sought to be restricted pertains solely to a health care item or service for which you, or a person other than the health plan on your behalf, has paid the covered entity in full.
- You have the right to ask us to restrict disclosures to persons involved in your health care. We will accommodate reasonable requests in non-emergency situations.
- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send your PHI to a different address from that of your subscriber. We will accommodate reasonable requests.
- With limited exceptions, you have the right to inspect and obtain a copy of health information that is contained in a “designated record set” – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. This right does not include: psychotherapy notes under certain circumstances; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and certain information maintained pursuant to the Clinical Laboratory Improvements Amendments of 1988. We may ask you to make your request in writing. We may charge a reasonable fee for producing and mailing the copies and, in certain cases, we may deny the request. If the request is granted and your health information is maintained electronically, we will provide your health information in the electronic form and format you requested, provided the information is readily producible in such form and format. If not readily producible as requested, we will produce your health information in a readable electronic form and format that we agree upon mutually.
- You have the right to ask us to amend incorrect or incomplete health information that is in a designated record set. Your request must be in writing and must include the reason for the request.
- You have the right to ask us to provide an accounting of disclosures that we have made about you without your permission for purposes other than treatment, payment, health care operations, and certain other activities. The accounting will include only disclosures made in the six (6) years prior to the request. We may ask you to make your request in writing and, to the extent permitted by law, we may charge a reasonable fee for producing and mailing the accounting.
- If you receive this notice on our web site or by electronic mail (e-mail), you have the right to receive a paper copy of this notice.

Complaints

If you think your privacy rights have been violated, or you disagree with a decision we made about access to your medical information, about amending your medical information, about restricting our use or disclosure of your PHI, or about how we communicate with you about your medical information (including a breach notice communication), or you have other purported violations to report, you may file a complaint. We will not retaliate in any way if you choose to file a complaint.

You may complain to us by submitting a written complaint to the address provided at the end of this notice. Alternatively, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Please be aware that certain federal jurisdictions may not apply to government status plans. For more details regarding government status plans, please contact the Plan Administrator.

Our Legal Obligations

We are required to keep PHI private, to give you notice of our legal duties and privacy practices, to modify affected individuals following a breach of unsecured PHI, and to follow the terms of this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all the information that we already have about you, as well as any information that we may receive or hold in the future.

Any changes to this notice will be provided to you either electronically and/or by mail. In the event of a material change to this notice, the revised notice (or information about the material change(s)) will be posted prominently on our website, if applicable, by the effective date of the material change(s), and/or will be mailed to you in a timely manner either in an independent mailing or with our next annual mailing (unless required earlier by law).

Contact Information

For additional information about this notice, to file a complaint, or to obtain a current list of names of persons who may be contacted regarding this notice, please contact your Employer or plan representative.

In the event of a conflict, the HIPAA and the controlling regulations will apply. This notice shall automatically incorporate any required changes in applicable law.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave our job to perform military service, you have a right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Notice Requirements – To be protected by USERRA and to continue health coverage, an employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the employee may elect to continue coverage at the first available moment and the employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

See your Employer or the plan representative for current notices and additional information regarding your right to continued coverage under USERRA including time periods, dependent coverage rights, maximum periods of coverage and costs.

Health Insurance Marketplace Coverage (2014)

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain standards. If the cost of the plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the “minimum value standard” if the Plan's share of the total allowed benefit costs covered by the Plan is no less than 60 percent of such costs.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please refer to the benefit descriptions of this SPD or contact the Plan Administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for insurance coverage and contact information for a Health Insurance Marketplace in your area. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide certain information about your health coverage offered by your employer.

General Notice of COBRA Continuation of Coverage Rights

This notice contains important information about your right to COBRA continuation coverage under the Plan. The right to COBRA continuation coverage is created by a federal law. Private sector plans are subject to COBRA rules under ERISA and the Consolidated Omnibus Budget Reconciliation Act of 1985. Government plans, including the Pima County Plan, are subject to COBRA continuation requirements under the Public Health Services Act, 42 U.S.C. Sections 300bb-1 through 300bb-8. There are differences between these two types of COBRA benefits. For example, regulatory oversight for governmental plan COBRA is vested in the US Department of Health and Human Services (with advisory jurisdiction through CMS) rather than the US Department of Labor.

COBRA is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact your Employer or the plan representative.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose their coverage under the Plan because of any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if retiree health is offered), or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan within 60 days [unless the Plan grants an extended period] after the qualifying event occurs. You must provide this notice to the designated Plan representative.

How is COBRA Coverage Provided?

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. See the Plan representative to find out if additional procedures or information or documentation is required.

Second qualifying event extension of 18-month period of continuation coverage

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your Employer or the designated Plan representative. For more information about your rights under the Public Health Services Act, contact the US Department of Health and Human Services or CMS. (Addresses and phone numbers of Regional and District Offices are available through agency websites.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan.

Note: There may be other coverage options for you and your family. When key parts of federal health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the Plan generally does not accept late enrollees, if you request enrollment within 30 days.

COMPLIANCE WITH FEDERAL BENEFITS LAWS; ADMINISTRATIVE PROCEDURES

The Employer or its designee may publish such additional notices, forms and administrative policies as necessary to comply with applicable federal benefits law requirements and changes thereto. The Plan shall be deemed automatically amended to incorporate applicable federal law and changes thereto to the extent necessary for compliance, and notices, forms and administrative policies made may be adopted consistent therewith.