BENEFIT PLAN

WA Silver Polyclinic PPO 2000 80/50 HSA-T

Aetna Life Insurance Company
Booklet-Certificate

This Booklet-Certificate is part of the Group Insurance Policy between Aetna Life Insurance Company and the Policyholder
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*Defines the Terms Shown in Bold Type in the Text of this Document.
Preface

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

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

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

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

This is a Preferred Provider Organization (PPO) medical plan which uses the Polyclinic Aetna Whole Health network of providers to provide medical services. A list of providers can be found at Aetna's online provider directory, DocFind® at www.aetna.com. You can also call the Member Services phone number listed on your ID card to request a copy of this directory.

Group Policyholder: XXXXX
Group Policy Number: GP-XXXX
Effective Date: XXXX
Issue Date: XXXX

Mark T. Bertolini
Chairman, Chief Executive Officer and President
Aetna Life Insurance Company
(A Stock Company)
Important Information Regarding Availability of Coverage

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

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

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

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

Please refer to the sections, “When Coverage Ends” and “Continuation of Coverage” for more details about these provisions.

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

Coverage for You and Your Dependents

Health Expense Coverage

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

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

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

Treatment Outcomes of Covered Services

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

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

Who Can Be Covered

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

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

Determining if You Are in an Eligible Class
You are in an eligible class if:
- You are a regular full-time employee, as defined by your employer.

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

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

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

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

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

- Your legal spouse; or
- Your domestic partner and
- Your dependent children; and
- Dependent children of your domestic partner.

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. You may appeal if you disagree with Aetna’s determination.
Coverage for Dependent Children
To be eligible for coverage, a dependent child must be under 26 years of age.

An eligible dependent child includes:

- Your biological children.
- Your stepchildren.
- Your legally adopted children.
- Your foster children, including any children placed with you for adoption.
- Any children for whom you are responsible under court order.
- Your grandchildren in your court-ordered custody.
- Any child whose parent is your child and your child is covered as a dependent under this plan.
- Any other child with whom you have a parent-child relationship and have provided, during the most calendar year, more than 50% financial support.

Coverage for Domestic Partner not registered in the State of Washington
To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.

A domestic partner is a person who certifies the following as of the date of enrollment:

- He or she is your sole domestic partner and intends to remain so indefinitely.
- He or she is not married or legally separated from anyone else.
- He or she has not registered as a member of another domestic partnership within the past six months.
- He or she is of the age of consent in your state of residence.
- He or she is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside.
- He or she has cohabitated and resided with you in the same residence for the past six months and intends to cohabitate and reside with you indefinitely.
- He or she is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses.
- He or she is not in the relationship solely for the purpose of obtaining the benefits of coverage.
- He or she can demonstrate interdependence with you by submitting proof of at least three of the following:
  - Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
  - Common ownership of a motor vehicle;
  - Driver’s license listing a common address;
  - Proof of joint bank accounts or credit accounts;
  - Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under your will; or
  - Assignment of a durable property power of attorney or health care power of attorney.

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

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

- Both an employee and a dependent; or
- A dependent of more than one employee.
How And When To Enroll

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

You will need to enroll within 31 days of your eligibility date. 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.

After the initial enrollment period, newborns, adopted children and children placed with you for adoption are automatically covered for 60 days after birth, adoption or placement for adoption. If the addition of your newborn or adopted child will increase your premiums, you will need to complete a change form and return it to your employer within the 60-day enrollment period to continue coverage for your child.

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.

Department of Social and Health Services Determination
If you are eligible for medical assistance in Washington, the Department of Social and Health Services may determine that it is cost effective for you to be enrolled in this plan. Upon notification of such determination, Aetna will allow you and any similarly qualified dependents to enroll in this plan. For a dependent child, the request for enrollment must be made within 60 days of the date of department’s determination.

Special Enrollment Periods
You or your eligible dependents may qualify to enroll 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 or your dependents experience one of the following qualifying events:

- Loss of coverage due to loss of employer sponsored coverage (for any reason) other than your voluntary termination of the coverage, fraud or misrepresentation of material fact.
- Loss of coverage can include but is not limited to:
  - 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 of marriage, or termination of domestic partnership
- 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;
- Birth, placement for adoption or adoption of a dependent
A permanent change in residence, work or living situation, whether or not within your choice where the health plan under which you were covered does not provide coverage in your new service area.

- Loss of individual or group health exchange coverage due to an error by the exchange, the issuer, or the United States Department of Health and Human Services.
- 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 have reached the lifetime maximum of another plan for all benefits under that plan; or
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

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

- 60 days of when the above qualifying event of special enrollment occurs; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of a qualifying event for Special Enrollment must be provided to Aetna. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

**New Dependents**

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

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

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

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

If the special enrollment will result in additional premiums, you will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to Aetna within 60 days of the addition of a spouse or dependent child, by birth, adoption, or placement with you for adoption. If you do not return the form within this timeframe, you will need to make the changes during the next open enrollment period unless you qualify for another special 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
- If adding the child as a covered dependent results in a change of premium, you request coverage for the child in writing within 60 days of the placement.
- Proof of placement will need to be presented to Aetna prior to the dependent enrollment.

**When You Receive a Qualified Child Support Order**

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

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

Coverage for the dependent will become effective on the date of the court order.
If you do not request coverage for the child within the 60 day period, you will need to wait until the next annual enrollment period.

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

**When Your Coverage Begins**

**Your Effective Date of Coverage for Annual Enrollment and Special Enrollment Periods**

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

- The date you are eligible for coverage or
- The date your application is received and approved in writing by Aetna.

You must return your completed enrollment information within 31 days of your eligibility date, unless the rules under the *Special Enrollment Period* section apply.

If you enroll before the last of the month, your coverage will begin the first day of the following month.

**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. For special enrollment events the effective date for your dependent coverage is the date of birth, adoption or placement for adoption. For dependents resulting from marriage or the commencement of a domestic partnership, coverage will begin the first day of the month immediately following the date of marriage or domestic partnership.
How Your Medical Plan Works

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

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

Important Notes:

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

Common Terms

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

About Your PPO Medical Plan

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

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

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

Some services and supplies may only be covered through network providers. Refer to the Covered Benefit sections and your Schedule of Benefits to determine if any services are limited to network coverage only.
Your out-of-pocket costs may vary between network and out-of-network benefits. Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

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

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

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

**How Your PPO Medical Plan Works**

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

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

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

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

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

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

Existing Enrollees

The following applies when your hospital or health care provider:

- No longer participates with Aetna as a network provider for reasons other than imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board that impairs the heath professional’s ability to practice.

Aetna will continue coverage for an ongoing course of treatment with your current hospital or health care provider during a transitional period. Coverage may continue for up to 90 days from the date of notice to you from Aetna that the provider no longer participates with Aetna as a network provider.

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

The coverage will be authorized by Aetna for the transitional period only if the hospital or health care provider agrees:

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

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

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

New Enrollees

If your current hospital or health care provider does not have a contract with Aetna, new enrollees may continue an ongoing course of treatment with their current hospital or health care provider for a transitional period of up to 90 days from the effective date of enrollment. If you have entered the second trimester of pregnancy as of the effective date of enrollment, the transitional period shall include the period of time that postpartum care directly related to the delivery is provided. You need to complete a Transition of Coverage Request form and send it to Aetna. Contact Member Services at the number on the back of your ID card for a copy of this form. If authorized by Aetna, coverage will be provided for the transitional period but only if the hospital or health care provider agrees to:

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

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

Accessing Network Providers and Benefits

- You may select a health care provider or PCP or other direct access network provider from the network provider directory or by logging on to Aetna’s website at www.aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of health care providers and facilities. You can change your PCP at any time.
If a service or supply you need is covered under the plan but not available from a network provider or hospital in your area, please contact Member Services by email or at the toll-free number on your ID card. We will assist in locating and approving an out-of-network provider. If there is an absence of, or an insufficient number or type of network provider or hospital, services will be provided at no greater cost than if the services were provided from a network provider or hospital.

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

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

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

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

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

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

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

- If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

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

**Cost Sharing for Out-of-Network Benefits**

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

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

**Understanding Medical Precertification**

**Precertification**

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

You do not need to **precertify** services and supplies provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the **network provider’s** responsibility, there is no additional out-of-pocket cost to you as a result of a **network provider’s** failure to **precertify** services and supplies.
When you go to an out-of-network provider, it is your responsibility to obtain precertification from Aetna for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced. The list of services and supplies requiring precertification appears later in this section.

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

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

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

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

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-emergency admissions</td>
<td>You, your health care provider or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</td>
</tr>
<tr>
<td>For an emergency medical condition</td>
<td>You or your health care provider should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible. Precertification is not required prior to stabilization.</td>
</tr>
<tr>
<td>For an emergency admission</td>
<td>You, your health care provider or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission</td>
<td>You, your health care provider or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a health care provider due to the onset of or change in an illness, the diagnosis of an illness, or an injury.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification</td>
<td>You or your health care provider must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

Aetna will provide a written notification to you and your health care provider of the precertification decision, where required under applicable State law. If your precertified services are approved, the approval is valid for 180 days as long as you remain enrolled in the plan. Premium that is due and unpaid at the time the precertified treatment/services are performed must be paid in full within the required timeframe.

When you have an inpatient admission to a facility, Aetna will notify you, your health care provider and the facility about your precertified length of stay. If your health care provider recommends that your stay be extended, additional days will need to be certified. You, your health care provider, 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 health care provider will receive a notification of an approval or denial.

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

**Precertification** is required for the following types of medical expenses:

### Inpatient and Outpatient Care

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Stays in a treatment facility for treatment of mental disorders, chemical dependency treatment (not including detoxification treatment), except for stays due to involuntary commitment to a state hospital as defined by law;
- Cosmetic and reconstructive surgery;
- Home Health Care;
- Emergency transportation by airplane;
- Injectables, (immunoglobulins, growth hormones, Multiple Sclerosis medications, Osteoporosis medications, Botox, Hepatitis C medications);
- Kidney dialysis;
- Outpatient back and Knee Surgery not performed in a health care provider’s office;
- Sleep studies;
- Knee surgery; and
- Wrist surgery;
- Complex Imaging;

### How Failure to Precertify Affects Your Benefits

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

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

### How Your Benefits are Affected

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

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

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

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

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

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

In Case of a Medical Emergency
An emergency medical condition is an emergent and acute condition, sickness, or injury, including (but not limited to) severe pain, which would lead a prudent layperson (including the parent or guardian of a minor child or the guardian of a disabled individual) possessing an average knowledge of medicine and health, to believe that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy;
- Serious impairment to a bodily function(s);
- Serious dysfunction to a body part(s) or organ(s); or
- In the case of a pregnant woman, serious jeopardy to the health of the unborn child.

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 health care provider provided a delay would not be detrimental to your health.
- If you are admitted to an inpatient facility, notify your health care provider as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition (one that does not meet the criteria above), 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

Covered expenses include charges made by a hospital or a health care provider for services and supplies provided in an emergency room to evaluate and treat an emergency medical condition.

Please contact your health care provider after receiving treatment of an emergency medical condition. Precertification for emergency admissions to a hospital is not required. However, continuation of your inpatient stay after your emergency medical condition is stabilized does require precertification. You, your health care provider, or the hospital must request precertification for your continued inpatient care to be covered expenses.

With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will pay a reduced benefit or 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.

In Case of an Urgent Condition

An urgent condition is a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a hospital emergency room; and
- Requires immediate outpatient medical care that cannot wait for your health care provider to become available.

Call your health care provider, if you think you need urgent care. Health care providers usually provide coverage 24 hours a day, including weekends and holidays for urgent care. You may contact any health care facility or urgent care facility, in- or out-of-network, for an urgent care condition if you cannot reach your health care provider.
If it is not feasible to contact your health care provider, please do so as soon as possible after urgent care is provided. If you need help finding a network urgent care facility you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna’s online provider directory at www.aetna.com.

**Coverage for an Urgent Condition**
The plan will pay for the services and supplies of a hospital or urgent care facility to evaluate and treat an urgent care condition.

**Non-Urgent Care**
If you seek care from an urgent care facility for a non-urgent condition (one that does not meet the criteria above), the non-urgent care is not covered. Please refer to the Schedule of Benefits for specific plan details.

**Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition**
Follow-up care is not considered an emergency medical condition or urgent care 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 health care provider for any necessary follow-up care. For coverage purposes, follow-up care is treated as an expense for routine illness or injury. If you access a hospital emergency room for follow-up care, your expenses will not be covered or coverage will be reduced and you will be responsible for the entire cost of your treatment or more of the cost of your treatment. Refer to the Schedule of Benefits for cost sharing information applicable to your plan.

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.

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

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

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

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

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

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

   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 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 or 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 health care provider specialty society recommendations and the views of health care providers 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

PPO Medical Plan

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

Preventive Care Benefits

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

Important Reminder:

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

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

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

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

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

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

Covered expenses include charges made by your health care provider or 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 health care provider 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.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendations from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention.
- For infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics, the Recommended Uniform Screening Panels by the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children;
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- For females, evidence-informed preventive care, screenings and counseling recommended in the comprehensive guidelines supported by the Health Resources and Services Administration.

For more detailed information regarding Preventive Care please visit: www.healthcare.gov/what-are-my-preventive-care-benefits; or the United States Preventative Service Task Force, (USPSTF) website at: www.uspreventiveservicestaskforce.org.

and


You may also call Aetna Member Services at the toll-free number on your ID card.

Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges for:
- Services which are covered to any extent under any other part of this Plan;
- Services 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 health care provider or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams, except this does not apply to depression screening counseling in a primary care setting.

Preventive Care Immunizations

Covered expenses include charges made by your health care provider, primary care physician (PCP) or a facility for:

- Immunizations for infectious diseases; and
- The materials for administration of immunizations;

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

Limitations
Not covered under this Preventive Care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this plan; and
- Immunizations that are not considered Preventive Care such as those required due to your employment or travel.
Well Woman Preventive Visits

- **Covered expenses** include charges made by your **health care provider, primary care physician (PCP)**, 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 **health care provider** 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 **health care provider** or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams except this does not apply to depression screening counseling in a primary care setting.

**Screening and Counseling Services**

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

**Obesity and Healthy Diet Counseling**
Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Nutritional counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

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

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

Coverage includes:

- Preventive counseling visits;
- Treatment visits; and
- Class visits;

to aid you to stop the use of tobacco products.
Tobacco product means a substance containing tobacco or nicotine including:
- Cigarettes;
- Cigars;
- Smoking tobacco;
- Snuff;
- Smokeless tobacco; and
- Candy-like products that contain tobacco.

**Sexually Transmitted Infection Counseling**

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

**Genetic Risk Counseling for Breast and Ovarian Cancer**

**Covered expenses** include the counseling and evaluation services to assess whether or not you are at risk of breast and ovarian cancer susceptibility.

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

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

**Routine Cancer Screenings**

**Covered expenses** include, but are not limited to, charges incurred for routine cancer screening as follows:
- Mammograms;
- 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 screenings.

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

Although not included in the guidelines recommended by the United States Preventive Services Task Force or the guidelines supported by the Health Resources and Services Administration, this Plan also covers Colonoscopies for covered persons less than 50 years of age and at high risk or very high risk for colorectal cancer.

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

**Important Reminder:**
1. Refer to the *Schedule of Benefits* for details about cost sharing and benefit maximums that apply to *Preventive Care*.
2. For details on the frequency and age limits that apply to *Routine Physical Exams* and *Routine Cancer Screenings*, contact Member Services. Log onto the Aetna website www.aetna.com or call at the number on the back of your ID card.
Prenatal Care

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

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

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

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

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

Comprehensive Lactation Support and Counseling Services

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

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

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

Payment of charges will be made up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. Aetna may decide to purchase an item instead of renting one.

Coverage is 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 following the date of the birth; 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 an electric 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.
Limitations:
Unless specified above, not covered under this Preventive Care benefit are charges incurred for services which are covered to any extent under any other part of this plan.

Family Planning Services - Female Contraceptives

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

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

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

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

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

Contraceptives
Covered expenses include charges made by a health care provider for contraceptive drugs and devices. Coverage includes the related services and supplies provided by, administer or removed by a health care provider during an office visit.

Important Reminder:
Refer to the section “Other Covered Pharmacy Expenses” later in this Booklet-Certificate for additional coverage of female contraceptives.

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 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 health care provider or under his or her direction;
• Psychiatric, psychological, personality or emotional testing or exams except this does not apply to depression screening counseling in a primary care setting.
• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; and
• The reversal of voluntary sterilization procedures, including any related follow-up care.

Chronic Disease Management
Aetna has established a health management (Chronic Disease) program to help prevent, detect and monitor problems early on to help you and your covered dependents stay healthy through all stages of your life. The following is a list that includes, but is not limited, to the conditions that are supported under this program.
<table>
<thead>
<tr>
<th>Vascular</th>
<th>Pulmonary</th>
<th>Neuro-Geriatric</th>
<th>Renal</th>
<th>Other</th>
<th>Cancer</th>
<th>Renal</th>
<th>Other</th>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Heart failure</td>
<td>• Asthma – adult &amp; pediatric</td>
<td>• Geriatrics</td>
<td>• Chronic kidney disease</td>
<td>• Weight management –</td>
<td>• General cancer</td>
<td>• End stage renal failure</td>
<td>• Cystic fibrosis –</td>
<td>• HIV(human immunodeficiency virus</td>
</tr>
<tr>
<td>• Diabetes – adult &amp; pediatric</td>
<td>• Chronic obstructive pulmonary disease (COPD)</td>
<td>• Migraines</td>
<td>• End stage renal failure</td>
<td>• adult &amp; pediatric</td>
<td>• Breast cancer</td>
<td>• Hypercoagulable state</td>
<td>• Lung cancer</td>
<td>• Hypercoagulable state (blood clotting)</td>
</tr>
<tr>
<td>• Coronary artery disease (CAD)</td>
<td>• Osteoporosis</td>
<td>• Seizures</td>
<td>• Sickle cell disease – adult &amp; pediatric</td>
<td>• Rheumatoid arthritis (RA)</td>
<td>• Lung cancer</td>
<td>• Sickle cell disease – adult &amp; pediatric</td>
<td>• Depression</td>
<td>• Colorectal cancer</td>
</tr>
<tr>
<td>• Peripheral artery disease (PAD)</td>
<td>• Osteoarthritis (OA)</td>
<td>• Parkinsonism</td>
<td>• Depression</td>
<td>• Chronic lower back pain</td>
<td>• Prostate cancer</td>
<td>• Depression</td>
<td>• Cholesterol</td>
<td>•</td>
</tr>
</tbody>
</table>
Additional Covered Medical Expenses

Family Planning Services - Other

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

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

Limitations:
Not covered are:
- Male contraceptive methods or devices;
- Reversal of voluntary sterilization procedures, for males and females, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this plan.

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

Vision Care Benefits

Pediatric Routine Vision Screening and Comprehensive Exams
Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for a routine vision screening and a comprehensive eye exam, including refraction, glaucoma testing and dilation as professionally indicated, every calendar year.

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

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

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses.
- Eyeglass frames, prescription lenses or prescription contact lenses identified by a vision network provider. These are eyeglass frames, prescription lenses including polycarbonate lenses and scratch resistant coating, or prescription contact lenses that are covered at 100% by a vision network provider.

Coverage includes charges incurred for:

- Single vision, conventional lined bifocal, conventional lined trifocal or lenticular lenses.
- Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses.
- Aphakic prescription lenses prescribed after cataract surgery has been performed.
- Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision as follows:
  - One comprehensive low vision evaluation every five years;
  - High power spectacles, magnifiers and telescopes as medically necessary, with reasonable limitations permitted; and
  - Follow-up care of four visits in any five year period, if preauthorized.
This benefit is subject to an age limit as shown on the Schedule of Benefits.

A listing of the locations of the vision network providers, including Eyemed vision network providers can be accessed at the www.aetna.com website. You must present your ID card to the vision network provider at the time of service.

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

Limitations:
Unless specified above, this benefit does not cover the following services and supplies:
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes.
- Eyeglass frames, prescription lenses or prescription contact lenses identified by a vision non-network provider.

Benefits for Vision Care Services and Supplies After Your Coverage Terminates
If your coverage under this plan terminates while you are not totally disabled, covered expenses under this plan will include charges that you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:
- A complete vision exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in contact or frame lenses being prescribed for the first time, or new contact or frame lenses ordered due to a change in prescription.

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

Health Care Provider Services

Health Care Provider Visits
 Covered medical expenses include charges made by a health care provider during a visit to treat an illness or injury. The visit may be at the health care provider’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 solely required due to your employment or for travel;
- Allergy testing, treatment and injections; and
- Charges made by the health care provider for supplies, radiological services, x-rays, and tests provided by the health care provider.
- Charges made by the health care provider for a second opinion consultation prior to treatment or procedure.

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

Surgery
 Covered expenses include charges made by a health care provider for:
- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another health care provider to obtain a second opinion prior to the surgery.
Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a health care provider, other than the operating health care provider, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

General Anesthesia for Dental Procedures
Covered expenses include charges for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a hospital or ambulatory surgical center if such services are medically necessary because the covered person:

- Is age 8 and younger, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office, or
- Has a medical condition that the person’s health care provider determines would place the person at undue risk if the dental procedure were performed in a dental office.

Covered expenses include medically necessary general anesthesia services in conjunction with any covered procedure performed in a dental office if the services are medically necessary because the covered person is age 8 or younger or physically or developmentally disabled.

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

Alternatives to Health Care Provider Office Visits

Walk-In Clinic Visits
Covered expenses include charges made by walk-in clinics for:

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

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

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

Important Reminder:
- Not all services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic.
- For a complete description of the screening and counseling services provided on the use of tobacco products, healthy diet and to aid in weight reduction due to obesity, refer to the Preventive Care Benefits section in this Booklet-Certificate and the Screening and Counseling Services benefit for a description of these services.
- These services may also be obtained from your physician or PCP.
E-Visits and Telemedicine
Covered expenses include charges made by your health care provider for a routine, non-emergency, medical consultation. You must make your E-visit or telemedicine appointment through an Aetna authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetna.com or by calling the number on your identification card.

Hospital Expenses
Covered 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 or because the hospital only has private rooms. In the event a network hospital has only private rooms, the covered expenses will equal the negotiated charge. For out-of-network hospitals, covered expenses are based on recognized charges.

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
- Health care providers and surgeons
- Operating and recovery rooms
- Intensive or special care facilities
- Administration of blood and blood products
- Radiation therapy
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Dialysis Services delivered in a hospital
- Respite care services delivered in a hospital
Outpatient Hospital Expenses
Covered expenses include hospital charges made for covered services and supplies including dialysis provided by the outpatient department of a hospital.

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

Hospital admissions need to be precertified by Aetna. Refer to Understanding Medical Precertification for details about precertification.

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

Pregnancy Expenses
Covered expenses include charges made by attending health care provider for pregnancy and childbirth services including complication of pregnancy, such as, but not limited to fetal distress, gestational diabetes, and toxemia and in utero treatment 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 longer hospital stay as determined by the attending health care provider, in consultation with the mother, as medically necessary and based on accepted medical practice; or
- A shorter stay, if the attending health care provider, with the consent of the mother, discharges the mother or newborn earlier.
- If the mother is discharged earlier, the plan will pay, at a minimum, for two post-delivery home visits by a health care provider. Post-delivery care as determined by the attending health care provider, in consultation with the mother, as medically necessary and based upon accepted medical practice is a covered expense.
- Coverage for the newborn child for the first three weeks after birth is the same as the mother’s coverage.

Aetna will not impose a limitation on maternity services that would require a birth to occur in a hospital and will not impose a requirement that a health care provider conduct a delivery.

Home Births- Expenses related to a home delivery, when determined by the attending health care provider to be a low risk delivery, are covered expenses.

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

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

Birthing Center Facility and Health Care Provider’s Expenses
Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:
- Prenatal care;
- Delivery; and
- Postpartum care as determined by the attending health care provider, in consultation with the mother, as medically necessary and based on accepted medical practice.

See Pregnancy Expenses for information about other covered expenses related to pregnancy and childbirth services and supplies.
Alternatives to Hospital Stays

Outpatient Surgery and Health Care Provider Surgical Services

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

- A health care provider 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 health care provider’s or dentist’s office.

Important Note:
Benefits for surgery services performed in a health care provider's or dentist's office are described under health care provider 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 health care provider’s services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another health care provider 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 health care provider who renders technical assistance to the operating health care provider.
- A stay in a hospital.
- Facility charges for office based surgery.

Home Health Care

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

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

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.
- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Dialysis services.
- Services provided for the treatment of a mental disorder or substance abuse disorder.
- Skilled behavioral health care services provided in the home by a behavioral health care 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, or convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
- The services are not for Applied Behavior Analysis
- Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or behavioral health provider or therapist is one visit.

In figuring the Home Health Care Maximum Visits, each visit of a:
- Nurse or Therapist of up to 4 hours is one visit.
- Behavioral health care provider, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:
- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

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

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

**Note:** Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation and Habilitation Therapies 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 for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

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

Home health care needs to be precertified by Aetna. Refer to Understanding Medical Precertification for details about precertification.

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

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

- **Room and board**, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or health care provider’s services);
- Medical supplies including pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;
- Respite care services delivered on an inpatient basis; and
- Services provided for the treatment of a mental abuse disorder or substance abuse disorder.

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

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

Admissions to a skilled nursing facility must be precertified by Aetna. Refer to Understanding Medical Precertification for details about precertification.

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

- Charges made for the treatment of senility; 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 health care provider. 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;
- Consultation or case management services by a health care provider;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Respite care

Covered expenses include charged for respite care provided on an inpatient and outpatient basis up to the maximums shown in the Schedule of Benefits.

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

- A health care provider 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 Understanding Medical Precertification for details about precertification.
Other Covered Health Care Expenses

Acupuncture

The plan covers charges made for acupuncture services provided by a health care provider, within the scope of his or her license, if the service is performed:

- As a form of anesthesia in connection with covered surgery; or
- To treat an illness, injury or alleviate chronic pain.

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.
- Non-emergency transport by fixed wing aircraft
Diagnostic and Preoperative Testing

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

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

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

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

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

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

Outpatient Preoperative Testing
Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, health care provider 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; or
- You were an inpatient in a hospital.

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.

Covered expenses under this Diagnostic and Preoperative Testing benefit includes diagnostic cardiovascular testing, diagnostic pulmonary function studies, diagnostic neurology/neuromuscular procedures, and ultrasound imaging.

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

Blood and Blood Products
Covered expenses include charges for the following:

- Blood;
- Blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors;
- Blood storage including the services and supplies of a blood bank; and
- Autologous blood donations, only administration and processing costs are covered.
Durable Medical and Surgical Equipment (DME)
Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental including sales tax:

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 including mobility enhancing equipment used to serve as a medical purpose unless excluded in the Medical Plan Exclusions section of this Booklet-Certificate. Aetna reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

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

Genetic Testing

Aetna considers genetic testing medically necessary to establish a molecular diagnosis of an inheritable disease when:

- The member displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered.

Covered expenses include the following:

- Charges made by a health care provider and lab for the test once per lifetime; and
- Charges made by a genetic counselor to interpret the test results and evaluate treatment, once per lifetime.

Please see the Prenatal Testing section for genetic testing of the fetus during pregnancy.

Prenatal Testing

Charges made by a hospital, diagnostic lab facility or a health care provider for prenatal tests are included as covered expenses.

Prenatal tests are screening and other diagnostic procedures which are performed during pregnancy to detect congenital or inherited disorders of the fetus.
**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;
- External breast prostheses, including bras made solely for use with external breast prostheses after a mastectomy and replacement bras due to usage;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for you;
- Splints, trusses, orthopedic appliances and orthotic devices and
- Supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts

**Limitations**

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

- an orthopedic shoe if it is an integral part of a covered leg brace; or
- corsets, and other support items; or
- any item listed in the Medical Plan Exclusions section.

**Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services**

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

- A licensed or certified physical or occupational therapist; or
- A health care provider.

Charges for the following short term rehabilitation expenses are covered:
Cardiac and Pulmonary Rehabilitation Benefits

Cardiac Rehabilitation Benefits

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient cardiac rehabilitation appropriate for your condition is covered for a cardiac condition that can be changed.

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

Pulmonary Rehabilitation Benefits

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

Limitations

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

- Any services unless provided in accordance with a specific treatment plan;
- Services not performed by a health care provider or under the direct supervision of a health care provider;
- Services provided by a health care provider or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family, or your domestic partner.

Short-Term Rehabilitation and Habilitation Therapy Services

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

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

Short-term rehabilitation services have to follow a specific treatment plan, ordered by your physician, that:
• Details the treatment, and specifies frequency and duration, and
• Provides for ongoing reviews and is renewed only if continued therapy is appropriate.
• Allows therapy services, provided in your home, if you are homebound

Outpatient Physical Therapy, Occupational Therapy, Massage Therapy, and Speech Therapy Rehabilitation Benefits

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. Inpatient rehabilitation and habilitation benefits for the services listed will be paid as part of your hospital and skilled nursing facility benefits provision in this Booklet-Certificate.

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

Speech therapy is covered provided that the therapy is expected to:
- significantly improve or restore the speech function or correct a speech impairment resulting from illness or injury; or surgical procedure;
or
- improve delays in speech function development as a result of a gross anatomical defect present at birth.
Speech function is the ability to express thoughts, speak words and form sentences.
Speech impairment is difficulty with expressing one’s thoughts with spoken words.

Cognitive therapy rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Neurodevelopmental therapy Treatment includes speech therapy, physical therapy or occupational therapy given to restore or improve a speech or body function; or to develop a speech or body function delayed by an illness or a congenital abnormality; or to maintain a speech or body function if, without therapy, an illness or congenital abnormality would cause significant deterioration in condition. Refer to the Schedule of Benefits for any visit maximums that may apply to this benefit.
Massage Therapy provided by a licensed massage therapist when overseen by an M.D. DO or DC

Outpatient services provided by a school district that are not delivered pursuant to the Individuals with Disabilities Education Act (IDEA) or an Individual Education Plan (IEP).

Refer to the Schedule of Benefits for the visit maximum that applies to the plan.

Important Reminder
Refer to the Schedule of Benefits for details about any applicable short-term rehabilitation therapy maximum benefit.

Limitations
Unless specifically covered above under Neurodevelopmental therapy or Outpatient services provided by school districts, not covered under this benefit are charges for:
- Educational services for Down's Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a health care provider or under the direct supervision of a health care provider;
- Treatment covered as part of Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a health care provider or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.
Spinal Manipulation Treatment
Covered expenses include charges made by a health care provider 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;
- For treatment of scoliosis;
- For fracture care; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating health care provider.

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

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

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

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

Outpatient physical therapy, occupational therapy, aural therapy and speech therapy
Covered expenses include:

- Physical therapy, if it is expected to develop any impaired function.
- Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to:
  - Develop any impaired function, or
  - Relearn skills to significantly develop your independence in the activities of daily living
- Speech therapy is covered provided the therapy is expected to:
  - Develop speech function as a result of delayed development
    (Speech function is the ability to express thoughts, speak words and form sentences).
- Aural Therapy including cochlear implants.

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

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

- Educational services for Down’s Syndrome and Cerebral Palsy, for example, as they are considered both developmental and/or chronic in nature;
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer.
- Any services unless provided in accordance with a specific treatment plan.
- Services provided during a stay in a hospital, skilled nursing facility, home health agency or hospice facility, except as stated above.
- Services not performed by a physician or under the direct supervision of a physician.
- Treatment covered as part of the Spinal Manipulation Benefit. This applies whether or not benefits have been paid under the Spinal Manipulation benefit.
• Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family or your domestic partner.

• Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

### Specialized Care

#### Reconstructive or Cosmetic Surgery and Supplies

*Covered expenses* include charges made by a **health care provider**, **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 is medically necessary and not cosmetic in nature.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an **illness** or **injury**) for newborn and dependent children.

#### 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**.

#### Experimental or Investigational Treatment

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

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status; and you are treated in accordance with protocol.

You are subject to all of the terms, conditions, provisions, limitations and exclusions of this plan including, but not limited to, **precertification** requirements.

#### Clinical Trial Expenses

Covered medical expenses include coverage for "**Patient Costs**" incurred by a covered person participating in clinical trials for treatment studies on cancer, including ovarian cancer or other life-threatening disease or condition.

Patient costs incurred during participation in clinical trials for treatment studies on cancer or other life-threatening disease or condition shall be determined in the same manner as reimbursement is determined for other medical and surgical procedure.

“Approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is: (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application. Covered Expenses also include routine costs for prescription medications provided in a clinical trial. Clinical trials medication that is the subject of the trial and any medication prescribed as part of the trial may be covered.

“Life threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.
"Patient Cost" is defined as the cost of a medically necessary health care service incurred as a result of treatment being provided to the covered person for purposes of a clinical trial.

NOTE: This definition excludes the cost of: (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial.

“Qualified individual” means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual’s participation in such trial is appropriate to treat the disease or condition, or the individual’s participation is based on medical and scientific information.

Coverage will be provided for patient costs incurred during clinical trials for treatment studies on cancer or other life-threatening disease or condition if treatment is provided by a clinic trial approved by:

- National Cancer Institute;
- An NCI cooperative group or NCI center;
- The FDA in the form of an investigational new drug application;
- The federal Department of Veterans Affairs, or
- An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Cancer Institute;

Important Notes:

1. Refer to the Schedule of Benefits for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit.

2. These Clinical Trial benefits are subject to all of the terms; conditions; provisions; limitations; and exclusions of this Plan including, but not limited to, any precertification requirements.

Outpatient Therapies

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

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

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

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

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

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

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

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

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

Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

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

Diabetes Benefits

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

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

**Equipment:**
- External insulin pumps; and
- Blood glucose monitors without special features unless required due to blindness.
Training:
• Self-management training provided by a licensed health care provider certified in diabetes self-management training.

Basic Infertility Expenses
Covered expenses include charges made by a health care provider to diagnose and to surgically treat the underlying medical cause of infertility.

Nutritional Supplements
Covered expenses include amino acid modified preparations, dietary specialized formulas and low protein modified food products for the treatment of inherited metabolic diseases including phenylketonuria and eosinophilic gastrointestinal disorder.

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

Jaw Joint Disorder Treatment
The plan covers charges made by a health care provider, 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 myofacial pain dysfunction (MPD).

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

Transplant Services
Covered expenses include inpatient and outpatient 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;
- Artificial organ transplants based on an issuer’s medical guidelines and manufacturer recommendations and
- 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; and
- 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 result in a reduction of benefits even if the facility is a network facility or IOE for other types of services.

The plan covers:

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

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

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

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

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

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.
Travel and Lodging Expenses:
Travel and Lodging Expenses are those expenses incurred by an IOE patient, and a companion and a donor to travel between the IOE patient’s home and the IOE facility, if the facility is located 100 miles or more from the IOE patient’s home. Travel expenses include those incurred for round trip air, train, or bus travel, but only in coach class. You must be approved by Aetna for this program before you incur the expenses, otherwise you will not be reimbursed.

The plan will reimburse you for some of the cost of your travel and lodging expenses up to the limits shown in the Schedule of Benefits. Your approval notification from Aetna will describe the process to follow for reimbursement. You will be required to submit proof of loss (receipts) to Aetna.

For details about this program, contact Member Services at the toll-free number on your ID card.

Important Reminders
To ensure coverage, all transplant procedures need to be precertified by Aetna. Refer to the Understanding Medical Precertification 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:

- 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;
- 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.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a health care provider, a dentist and hospital for:

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

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed for emergency care and extraction of teeth 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.
- Prepare jaw for radiation treatments of neoplastic disease.

Hospital services and supplies received for a stay required because of your condition.
Dental work, surgery and orthodontic treatment including emergency care needed to remove, repair, restore or reposition: teeth damaged, lost, or removed; or
  - Other body tissues of the mouth fractured or cut due to injury.

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

The treatment must be completed in the Calendar Year of the accident or in the next Calendar Year. Accident means a sudden; unexpected; and unforeseen; identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Policy. The occurrence or event must be definite as to time and place.

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.

**Autism Spectrum Disorders**

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

Covered expenses include charges made by a physician or behavioral health provider for services and supplies for the diagnosis and treatment of Autism Spectrum Disorder. The services and supplies must be ordered by a physician or a behavioral health provider.

Coverage also includes early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that:
  - Systematically change behavior; and
  - Are responsible for the observable improvement in behavior.

Limitations:

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

- Educational services for behavioral disorders listed as not covered in the Medical Plan Exclusions and Limitations section of the Policy.

**Treatment of Mental Disorders and Substance Abuse**

Covered expenses include charges made for the treatment of substance abuse and 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 the Medical Plan Exclusions section of this Booklet-Certificate for more information.

**Treatment of a Mental Disorder**

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers. For purposes of coverage under this section, “mental disorders” refers to diagnostic categories listed in the most current version of The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, including coverage for eating disorder treatment when associated with a diagnosis of a DSM categorized mental health condition. In addition to the exclusions in the Medical Plan Exclusions section of this Booklet-Certificate, the following categories are not covered as mental disorders:

- Substance-related disorders; and
- Life transition problems, currently referred to as “V” codes and diagnostic codes 302 through 302.9.
The following are not considered covered treatment of mental disorders:

- custodial care; and
- Court ordered treatment unless the plan’s medical director or designee determines the treatment to be medically necessary.

Unless specifically listed in the coverage descriptions below, coverage for mental disorders is limited as specified above.

### Important Reminders

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

### Covered expenses

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

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

- Outpatient treatment received while not confined as an inpatient in a hospital, or psychiatric hospital, including prescription drugs prescribed on an inpatient or residential basis including in home setting.

  **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a health care provider. The facility or program does not make a room and board charge for the treatment.

  - Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment) provided in a facility or program under the direction of a physician.

  - Office Visits to a physician (such as a psychiatrist), psychologist, social worker, or licensed professional counselor, as well as other health professionals.

**Covered expense** also include mental health services treatment delivered in a home health setting. Benefits are payable in the same way as those for any other disease.

### Important Reminders

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

### Treatment of Substance Abuse

### 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 section for more information.

### Covered expenses

Include charges made by a hospital, psychiatric hospital, residential treatment facility or behavioral health provider through an approved treatment program for the treatment of substance abuse as follows:

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

  As used here, “medical complications” include, but are not limited to, detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
• Outpatient treatment received while not confined as an inpatient in a hospital, or psychiatric hospital including prescription drugs prescribed on an inpatient or residential basis, or in home setting including.

Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) provided in a facility or program under the direction of a health care provider. The facility or program does not make a room and board charge for the treatment.

- Intensive Outpatient Program (at least 2 hours per day and at least six hours per week of clinical treatment) provided in a facility or program under the direction of a physician.

- Ambulatory detoxification –Outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications.

- Office visits to a physician (such as a psychiatrist), psychologist, social worker, or licensed professional counselor, as well as other health care professionals.

Covered expenses also include acupuncture treatment visits provided by a health care provider for the treatment of substance abuse; and substance use treatment delivered in a home health setting.

Benefits are payable in the same way as those for any other illness.

The Schedule of Benefits shows the benefits payable and applicable benefit maximums for the treatment of substance abuse.

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

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your health care provider 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 in this Booklet-Certificate.

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

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan’s Test) treatment of non-specific candida sensitivity, and urine autoinjections.

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

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

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

Services of blood donors, apheresis or plasmapheresis.
Charges for a service of supply furnished by an **out-of-network provider** in excess of the **recognized charge**.

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

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

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

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

**Custodial Care**.

Disposable outpatient supplies: including sheaths, bags, elastic garments, support hose, bandages, bedpans, and; 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 except for those medications listed as Preventive under the Prescription Drug Benefit;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Any **prescription drugs**, injectables, or medications or supplies provided by the employer or through a third party vendor contract with the employer;
- Any expenses for **prescription drugs**, and supplies covered under an Aetna Prescription Drug plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Prescription Drug plan will apply to the medical expense coverage; and
- Charges for any **prescription drug** for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

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

Any:

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

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.

E-Visits and teledicine - Out-of Network Providers Any services that are given by providers that are not contracted with Aetna as e-visit or teledicine providers. Any services that are not provided during an internet-based consult or via telephone.

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 except as described in the Preventive Care Drugs and Supplements and Nutritional Supplement provisions.

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

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

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

Hearing: Related services and supplies:

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

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

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

High Risk home births or births in a place not licensed to perform deliveries.

Infertility: any services, treatments, procedures or supplies except for the diagnosis of infertility including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

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

Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a health care provider’s practice;
- Charges to have preferred access to a health care provider’s services such as boutique or concierge health care provider 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.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your health care provider 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.

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

Services of a resident health care provider or intern rendered in that capacity.

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

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

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

Short-Term Rehabilitation Services -- Outpatient Cognitive Rehabilitation, Physical, Occupational and Speech Therapy

Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth, including:
- 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.

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);
- 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 health care provider as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-Related Services: The transplant coverage does not include charges for:

- Services and supplies furnished to a donor when the recipient is not a covered person;
- 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;

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

Vision-related services and supplies except for Pediatric Vision.
In addition, the plan does not cover:

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

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs intended to treat, or are related to the treatment of obesity, including morbid obesity;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- 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.
- Screening and counseling services to aid in weight reduction due to obesity are covered under your Plan. See Screening and Counseling Services under What Your Plan Covers section.

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.
Pediatric Dental Services

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

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

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

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

About the Pediatric PPO Dental Expense Insurance Plan

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

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

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

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

The Choice Is Yours

You have a choice each time you need dental care:

Using Network Providers

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

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

Using Out-of-Network Providers

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

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

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

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

Pediatric Dental Care Schedule

If:

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

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

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

- Diagnostic and Preventive Care
- Basic Restorative Care
- Major Restorative Care
- Orthodontic Care

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

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

Type A Pediatric Dental Expenses: Diagnostic and Preventive Care

Visits and Images

- Periodic Office visit for oral examination
- Complete oral evaluation, includes a complete dental and medical history, general health assessment, evaluation of extra-oral and intra oral hard and soft tissue; evaluation and recording of dental caries, missing teeth, unerupted teeth, restorations, occlusal relationships, periodontal conditions, periodontal charting, hard and soft tissue anomalies; oral cancer screening (limited to 1 per provider as an initial examination)
- Hospital visit (limited to 1 per day, per provider including emergency care)
- House/Extended care facility (limited to 2 visits per facility per calendar year per provider)
- Routine comprehensive or recall examination (limited to 2 visit per calendar year)
- Limited Oral Assessments/problem-focused examination, includes evaluation of a specific dental problem, dental emergency and/or referral for other treatment
- Screening or assessment of a patient to determine the need for sealants, fluoride treatment and/or triage services (limited to 2 per calendar year)
- Oral hygiene instructions includes individualized oral hygiene instructions, tooth brushing techniques, flossing and use of oral hygiene aids (limited to patients 8 years and under to 2 per calendar year)
- Prophylaxis (cleaning) (limited to 2 treatments per calendar year)
- Topical application of fluoride, (limited to three per year for children under 7 and per patient during orthodontic treatment and two per calendar year for children 7 to 18)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only) and one application every 2 years for developmentally disabled
- Bitewing images (limited to 1 set per calendar year)
- Periapical images
- Complete image series, including bitewings if medically necessary or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing images (limited to 1 set every 3 years)
- Periapical images (single films up to 13)
- Intra-oral, occlusal view, maxillary or mandibular
- Cephalometric film (limited to oral surgeon 1 film per 2 years)

**Space Maintainers**
- Only when needed to preserve space resulting from premature loss of primary teeth.
- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removal of a fixed space maintainer
- Replacement space maintainers on a case by case basis.

**Type B Pediatric Dental Expenses: Basic Restorative Care**

*Visits and Images*
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit
- Treatment of post-surgical complications

*Images and Pathology*
- Upper or lower jaw, extra-oral
- Biopsy and accession of tissue examination of oral tissue
- Pulp vitality test
- Diagnostic casts (when medically necessary)
- Oral or facial images (case-by-case basis)

**Oral Surgery**
- Extractions
  - Erupted tooth or exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty, in conjunction with extractions - per quadrant
  - Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Alveoplasty, not in conjunction with extraction - per quadrant
  - Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Removal of torus palatinus
  - Reduction of osseous tuberosity
  - Transplantation of tooth or tooth bud
  - Closure of oral fistula of maxillary sinus
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Frenuloplasty
Suture of soft tissue injury
Biopsy of soft oral tissue

**Periodontics**
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
- Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
- Gingivectomy or gingivoplasty, per quadrant
- Gingivectomy, or gingivoplasty 1 to 3 teeth per quadrant
- Periodontal maintenance procedures following active therapy (limited to 2 per calendar year)
- Localized delivery of antimicrobial agents

**Endodontics**
- Pulp capping
- Pulpectomy including therapeutic pulpectomy and pulpal debridement
- Pulpal therapy (resorbable fillings)
- Apicectomy/recalcification
- Apicoectomy
- Retrograde filling
- Root canal therapy including **medically necessary** images:
  - Anterior
  - Bicuspid
- Retreatment of previous root canal including medically necessary images:
  - Anterior
  - Bicuspid

**Restorative Dentistry**
- Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)
- Amalgam restorations
- Resin-based composite restorations (other than for molars)
- Pins
  - Pin retention—per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlays
  - Crowns
  - Bridges

**Type C Pediatric Dental Expenses: Major Restorative Care**

**Oral Surgery**
- Surgical removal of impacted teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

**Periodontics**
- Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
- Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
- Soft tissue graft procedures
**Endodontics**
- Molar root canal therapy including **medically necessary** images
- Molar retreatment of previous root canal

**Restorative**
- Inlays, onlays, labial veneers and crowns (limited to 1 per tooth every 5 years. See the *Replacement Rule* section).
- Inlays/Onlays (limited to 1 per tooth every 5 years)
- Crowns (limited to 1 per tooth every 5 years)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain/ceramic substrate
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - 3/4 cast metallic or porcelain/ceramic
- Post and core
- Core build-up

**Prosthodontics**
- Replacement of complete dentures is limited to one every 5 years. (See the *Replacement Rule* section.)
- Bridge Abutments (See Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable Bridge (unilateral) (limited to 1 every 3 years)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures limited to 1 every 5 years
- Partial (limited to 1 every 3 years)
  - *(Fees for dentures and partial dentures include relines, rebases and adjustments within 3 months after installation. Fees for relines and rebases include adjustments within 3 months after installation. Specialized techniques and characterizations are not eligible.)*
  - Complete upper denture (limited to 1 every 5 years.)
  - Complete lower denture (limited to 1 every 5 years.)
  - Immediate upper denture (limited to 1 every 5 years.)
  - Immediate lower denture (limited to 1 every 5 years.)
  - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than 3 months after installation
- Full and partial denture repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
  - Adding teeth to existing partial denture
  - Each tooth
Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for permanent dentition),
- Occlusal orthodic device (limited to patients 12 thru 18 years of age)

**General Anesthesia / Intravenous Sedation/ Oral or Parenteral Conscious Sedation**
- Only when medically necessary and only when provided in conjunction with a covered dental surgical procedure
- Drugs or medicaments
- Local anesthesia and regional blocks are covered as part of the global fee of the procedure being performed; and are not separately covered.
- Nitrous oxide, analgesia (limited to 1 administration per day)
- Administration of oral sedative

**Behavioral Health**
- Behavior management is covered when medically necessary. It is limited to when the assistance of an additional staff is required.

**Orthodontics**
- Medically necessary orthodontic treatment
- Replacement of retainer (limit one per lifetime)

**Getting an Advance Dental Claim Review**

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

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<tr>
<th>Important Note:</th>
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<td>The advance (pre-treatment review) process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.</td>
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**When to Get an Advance Dental Claim Review**

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

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

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

**What Is a Course of Dental Treatment?**

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

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

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

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

If you have a dental emergency, you may get treatment from any dentist. You should consider calling your dental network provider, if possible. Your dental network provider may be more familiar with your dental needs. If you are not able to reach your dental network provider or are away from home, you may get treatment from any dentist. You may also call Aetna Member Services at the toll-free telephone number on your ID card for help in finding a dentist.

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

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

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

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

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

Rules and Limits That Apply to the Dental Benefits

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

Orthodontic Treatment Rule
Orthodontic coverage must be medically necessary as having a severe, dysfunctional, handicapping malocclusion as determined by the Washington Modified Handicapping Labiolingual Deviation (HLD) Index Score with a score of 25 or higher and conditions that result in a score of less than 25 on a case-by-case basis. A severe, dysfunctional, handicapping condition includes conditions such as:

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

(B) The following craniofacial anomalies:
  - Hemifacial microsomia;
  - Craniostenosis syndromes;
  - Cleidocranial dental dysplasia;
  - Arthrogyrosis; or
• Marfan syndrome

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

(D) Facial trauma resulting in functional difficulties

Reimbursable orthodontic services include:
• pre-orthodontic treatment visit
• comprehensive orthodontic treatment
• orthodontic retention (removal of appliances, construction and placement of retainers(s)

This benefit does not cover charges for the following:
• Replacement of broken appliances;
• Re-treatment of orthodontic cases;
• Changes in treatment necessitated by an accident;
• Maxillofacial surgery;
• Myofunctional therapy;
• Lingually placed direct bonded appliances and arch wires (i.e. "invisible braces"); or
• Removable acrylic aligners (i.e. "invisible aligners").

Orthodontic treatment is any:
• Medical service or supply; or
• Dental service or supply;

that are medically necessary and 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;
• A surgical procedure to correct malocclusion; or
• Diagnostic casts included in orthodontic treatment.

Replacement Rule
Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:
• You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
• The present crown, inlay and onlay, veneer, complete denture or other prosthetic service was installed at least 5 years before its replacement and cannot be made serviceable.
• The present removable partial denture, fixed partial denture (bridge), was installed at least 3 years before its replacement and cannot be made serviceable.
• Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Coverage for Dental Work Completed After Termination of Coverage
Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends.
• Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

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

**Jaw Joint Disorder Treatment Rule**

Coverage for Jaw Joint Disorder treatment is covered as a Type C Service. This includes treatments which alter the jaw, jaw joints or bite relationships. The following are covered:
- Diagnosis;
- Applicable therapy; and
- Other non-surgical treatment.

Not included are charges incurred for:
- Orthodontic treatment;
- Crowns, bridges and dentures;
- Treatment of periodontal disease;
- Implants; and
- Root canal therapy.

**Pediatric Dental Plan Exclusions**

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

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

- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in the Booklet-Certificate.
- Any instruction for diet, plaque control and oral hygiene age 9 and older.
- Charges submitted for services:
  - By an unlicensed hospital, health care provider or other provider other than a licensed denturist; or
  - By a licensed hospital, health care provider or other provider that are not within the scope of the provider’s license.
- Charges submitted for services that are rendered, or not rendered to a person not eligible for coverage under the plan.
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons. Facings on molar crowns and pontics will always be
considered cosmetic.

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

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

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

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

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

- Orthodontic treatment, except as specifically provided in the Pediatric Dental Services section.

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

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

- Replacement of teeth beyond the normal complement of 32.

- Routine dental exams and other preventive services and supplies, except as specifically provided in the Pediatric Dental Services section.

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

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

- Services rendered before the effective date or after the termination of coverage.
• Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
• Surgical removal of impacted wisdom teeth only for orthodontic reasons.
• Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies.
• Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.
Your Pharmacy Benefit

How the Pharmacy Plan Works

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

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

A few important notes to consider before moving forward:

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

Notice

The plan does not cover all prescription drugs, medications and supplies. Refer to the Pharmacy Benefit Limitations and Exclusion section of this coverage and Medical Plan Exclusions section of your Booklet-Certificate.

- Covered expenses are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.

This plan covers only certain prescription drugs in accordance with the preferred drug guide. This plan does not cover all prescription drugs.

Getting Started: Common Terms

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

Accessing Pharmacies and Benefits

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

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

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

To better understand the choices that you have with your plan, please carefully review the following information.
Accessing Network Pharmacies and Benefits
You may select a network pharmacy from the Aetna Network Pharmacy Directory or by logging on to Aetna’s website at www.aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of network pharmacies. If you cannot locate a network pharmacy in your area, call Member Services.

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

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

Emergency Prescriptions
When you need a prescription filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your prescription at any network retail pharmacy. The network pharmacy will fill your prescription and only charge you your plan’s cost sharing amount. If you access an out-of-network pharmacy you will pay the full cost of the prescription and will need to file a claim for reimbursement. You will be reimbursed for your covered expenses up to the cost of the prescription less your plan’s cost sharing for network benefits. Coverage for prescription drugs obtained from an out-of-network pharmacy is limited to those obtained in connection with emergency care and out-of-area urgent care services.

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

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

- You will be responsible for the copayment or coinsurance, for each prescription or refill as specified in the Schedule of Benefits. The copayment or coinsurance, is payable directly to the network pharmacy at the time the prescription is dispensed.
  Your copayment or coinsurance will vary depending on the type of prescription drug, preferred generic drug, preferred brand drug, non-preferred generic and brand drug, or a Specialty drug (you pay the highest cost for these drugs).
  After you pay any applicable copayment you may also be responsible for any applicable coinsurance for covered expenses that you incur. Your coinsurance amount is determined by applying the applicable coinsurance percentage to the negotiated charge if the prescription is filled at a network pharmacy. When you obtain your prescription drugs through a network pharmacy, you will not be subject to balance billing.

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

This plan covers only certain prescription drugs in accordance with the preferred drug guide. This plan does not cover all prescription drugs.

You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Prescription drugs that are not listed on the preferred drug guide are excluded from coverage unless a medical exception is approved by Aetna. Refer to the Medical Exceptions described below for details. If it is medically necessary for you to use a prescription drug not on the preferred drug guide, you or your prescriber must request coverage as a medical exception.
Your **prescription drug** benefit may be subject to pharmacy management programs including, but not limited to **precertification**, **step therapy**, quantity limits and drug and narcotic utilization review. Refer to *Understanding Pharmacy Precertification* for further information. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for **covered expense**.

### Retail Pharmacy Benefits

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

You may qualify for the synchronization of your **prescription drugs** if you receive medications for chronic conditions. Synchronization allows for the coordination of your **prescription drug** refills used to treat chronic conditions, when dispensed through a retail **network pharmacy** or a **specialty pharmacy network pharmacy**.

### Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **mail order network pharmacy** for **Preferred** and **Non-Preferred prescription drugs**. Each **prescription** is limited to a maximum supply when filled at a **mail order network pharmacy**. The maximums are shown in the **Schedule of Benefits**.

### Injectable, Self-Injectable and Specialty Care Drug Benefits

#### Network Pharmacy Benefits

**Injectable drugs**, **self-injectable drugs** and **specialty care drugs** are covered at the network level of benefits only when dispensed through a retail **network pharmacy** or Aetna’s **specialty pharmacy network pharmacy**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to Aetna’s website, [www.aetna.com](http://www.aetna.com), to review the list of **injectable drugs**, **self-injectable drugs** and **specialty care drugs** required to be dispensed through a retail **network pharmacy** or a **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial **prescription** for **injectable drugs**, **self-injectable drugs** and **specialty care drugs** must be filled at a retail **network pharmacy** or at a **specialty pharmacy network pharmacy**.

You are required to obtain **injectable drugs**, **self-injectable drugs** and **specialty care drugs** at a **specialty pharmacy network pharmacy** for all **prescription drug** refills after the initial fill except in urgent situations.

### Over-the-Counter Prescription Drug Benefit

**Covered expenses** include certain over-the-counter medications, as determined by Aetna, in an equivalent prescription dosage strength for the appropriate **Preferred** and **Non-preferred** generic and **brand-name prescription drugs** at the appropriate member responsibility. Coverage of the selected over-the-counter medications require a **prescription**. You can access the list by logging onto [www.aetna.com](http://www.aetna.com).

### Orally administered anti-cancer drugs, including chemotherapy drugs

Orally administered anti-cancer drugs, including chemotherapy drugs may be covered when the drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature even if the drug is not approved by the FDA for a particular indication.
Other Covered Pharmacy Expenses
The following prescription drugs, medications and supplies are also covered expenses under this section.

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

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

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

Clinical Trial Use
Covered Expenses include routine costs for prescription medications provided in a clinical trial. Clinical trials medication that is the subject of the trial and any medication prescribed as part of the trial may be covered.

Diabetic Supplies
Covered expenses include, but are not limited to the following diabetic supplies upon prescription by a health care provider:

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

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

- Female contraceptives that are FDA-approved generic and brand name prescription drugs:
  - Oral drugs
  - Injectable drugs
  - Transdermal contraceptive patches
  - FDA-approved contraceptive vaginal rings that are generic. To the extent generic vaginal rings are not available, brand name vaginal rings will be covered.
  - FDA-approved female contraceptive devices that are generic and brand name devices

Covered expenses includes the related services and supplies needed to administer the device.

- FDA approved female generic emergency contraceptives. To the extent one of the emergency contraceptive methods are not available as a generic, a brand name emergency contraceptive will be covered. • Other FDA approved female generic and brand over-the-counter (OTC) contraceptives.
You may qualify for a medical exception. If your provider documents a medical exception and submits the exception to Aetna, certain FDA-approved brand or nonformulary contraceptives may also be covered as preventive.

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

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

Refer to your Schedule of Benefits for the Female Contraceptives - Copayment and Deductible Waiver provision (if applicable) for more information.

**Important Notes:**
1. The Copay and Deductible Waiver does not apply to contraceptive methods that are:
   - **Brand-name prescription drugs**;
   - FDA-approved female:
     - brand-name emergency contraceptives. To the extent one of the emergency contraceptive methods are not available as a generic, a brand name emergency contraceptive will be covered; and
     - brand-name over-the-counter (OTC) emergency contraceptives; and
   - FDA-approved female and male brand-name over-the-counter (OTC) contraceptives.

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

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

**Preventive Medications**

**Preventive Care Drugs and Supplements**

Covered expenses include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a retail network pharmacy. They are covered when they are:
- prescribed by a physician;
- obtained at a pharmacy; and
- submitted to a pharmacist for processing.
The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- **Aspirin**: Benefits are available to adults.
- **Oral Fluoride Supplements**: Benefits are available to children whose primary water source is deficient in fluoride.
- **Folic Acid Supplements**: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- **Iron Supplements**: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- **Vitamin D Supplements**: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.

**Risk Reducing Breast Cancer Prescription Drugs**

**Covered expenses** include **prescription drugs** when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing for a woman who is at:

- Increased risk for breast cancer, and
- Low risk for adverse medication side effects.

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

**Important Note:**

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

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

**Reimbursement of Preventive Care Drugs and Supplements at a Pharmacy**

You will be reimbursed by Aetna for the cost of the preventive care drugs and supplements when you submit proof of loss to Aetna that you purchased a preventive care drug or supplement at a **retail network pharmacy**.

“Proof of loss” means a copy of the receipt that contains the **prescription** information provided by the **pharmacist** (it is attached to the bag that contains the preventive care OTC drug or supplement).

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

**Tobacco Cessation Prescription and Over-the-Counter Drugs**

**Covered expenses** include all 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.

**Understanding Pharmacy Precertification**

**Precertification** is required for certain outpatient **prescription drugs**. **Prescribers** must contact Aetna to request and obtain coverage for such **prescription drugs**. We publish a list of those medications that currently require preauthorization which is updated on a periodic basis. An updated copy of the list of drugs requiring **precertification** shall be available upon request or may be accessed on line and can be found in the **Aetna preferred drug guide** available online at: http://fm.formularynavigator.com/MemberPages/pdf/MU14F06S131_2136_Full_0.pdf or you can call the Member Services toll free number on your ID card for further assistance. In addition, we notify Providers, including Pharmacies, which **Prescription Medications** require **preauthorization**.

Failure to request **precertification** will result in denial of coverage, so be sure to ask your **prescriber** or pharmacist if the drug being considered requires **precertification**.
How to Obtain Precertification
If an outpatient prescription drug requires precertification and you use a network pharmacy the prescriber is required to obtain precertification for you.

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

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

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

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

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

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

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

Pharmacy Benefit Limitations and Exclusions

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

The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required copayment or deductible, or for any prescription drug for which no charge is made to you.
Aetna retains the right to review all requests for reimbursement and in its discretion make reimbursement determinations subject to the Appeals section of the Booklet-Certificate.

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

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

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

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

Compounded prescriptions will be subject to non-preferred cost sharing.

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

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

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

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

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are covered expenses, but are limited to one (1) prescription order per calendar year.

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

Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your health care provider or dentist it may not be covered. The plan covers only those services and supplies that are 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 to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

Prescription Drug coverage is excluded for out-of-network pharmacy except for emergencies and urgent care. (See the Emergency Prescriptions section)

These prescription drug exclusions are in addition to the exclusions listed under your medical coverage. (See Medical Plan Exclusions section and other exclusions listed under What the Plan Covers)
The prescription drug expense provisions do not cover the following expenses:

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

Allergy sera and extracts

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

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

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

Any prescription drug or supply used for the treatment of sexual dysfunction/ enhancement in any form.

Any prescription drug in any form that is in a similar or identical class; has a similar or identical mode of action; or exhibits similar or identical outcomes.

Biological sera

Brand name prescription drugs and devices when a preferred or non-preferred generic or device equivalent or alternative is available, unless otherwise covered by medical exception.

Certain prescription drugs not listed under the preferred drug guide.

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

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

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

Drugs or medications that include the same active ingredient or a modified version of an active ingredient and:
- Is therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless medical exception is approved), or
- Is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless medical exception is approved).

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

Drugs recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutic Committee.
Drugs used primarily for the treatment of infertiltiy, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures.

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

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

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

Drugs used for the treatment of obesity.

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

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

**Experimental or investigational** drugs or devices except as described in the “Experimental or Investigational Treatment provision.”

This exclusion will not apply with respect to drugs that:

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

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition except as described in the “Preventive Care Drugs and Supplements and Nutritional Supplement” provisions.

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

Immunizations related to travel or work.

Injectables

- **Injectable drugs** dispensed by an out-of-network pharmacy;
- For any refill of a designated injectable drug, self-injectable drug and specialty care drug not dispensed by or obtained through the specialty pharmacy network pharmacy.

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

**Prescription drugs** unless the drug is included on the preferred drug guide or a medical exception is granted.

**Prescription drugs** dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
**Prescription drugs** that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the plan.

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

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

That are not considered covered or related to a non-covered service.

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

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

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

Prophylactic drugs for travel.

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

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

Replacement of lost or stolen prescriptions.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids when not medically necessary.

Test agents, except diabetic test agents.

**When Coverage Ends**

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

**When Coverage Ends for Employees**

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage under this plan;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
• Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, Aetna may deem your employment to continue, for purposes of remaining eligible for coverage under this plan, as described below:
  − If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer, but not beyond 3 months from the start of your absence.
  − If you are not actively at work due to temporary lay-off or leave of absence, your coverage will stop on your last full day you are actively at work before the start of the lay-off or leave of absence. (You may have continuation benefits. See the Continuation of Coverage section for additional information.)

It is your employer’s responsibility to let Aetna know when your employment ends. The limits above may be extended only if Aetna and your employer agree, in writing, to extend them.

When Coverage Ends for Dependents
Coverage for your dependents will end if:
• You are no longer eligible for dependents’ coverage;
• You do not make your contribution for the cost of dependents’ coverage;
• Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees section;
• Your dependent is no longer eligible for coverage under this plan. Coverage ends at the end of the calendar month when your dependent does not meet the plan’s definition of a dependent; or
• As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

• The date this plan no longer allows coverage for domestic partners.
• The date of termination of the domestic partnership. In that event, you should provide your Employer a completed and signed Declaration of Termination of Domestic Partnership.

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

Continuation of Coverage

Limited-Time Continuation
You and/or your dependents may continue coverage for up to three (3) months if you and/or your dependents are no longer eligible for coverage. You will be responsible to pay your premiums to continue coverage. This limited-time coverage is not available for those eligible for continuation coverage under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or, if your group policy ends or, if your employment ends for cause (termination for cause).

Handicapped Dependent Children
Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:
• he or she is not able to earn his or her own living because of a developmental disability or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
• he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age under your plan.
Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

**Continuation of Coverage During a Labor Dispute**

If your coverage under this plan would cease because you cease work due to a strike, lockout or other labor dispute, you can arrange to continue your coverage during your absence from work. You may make the premium payments to your employer. Your employer will transmit the payments to Aetna. Call the Member Services toll free number on your ID card for information on the premium payment process. Coverage may continue for up to 6 months. Continuation will cease when the first of these events occurs:

- You fail to make the required contributions;
- You go to work full time for another employer;
- The labor dispute ends; or
- The 6 month continuation period ends.

The monthly premium required by Aetna for each person’s coverage will be the applicable effective rate in effect on the date you cease work. If the premium paid by your employer changes during the time you are continuing coverage under this provision, your premiums will change correspondingly.

**COBRA Continuation of Coverage**

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

**Continuing Coverage through COBRA**

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.
Who Qualifies for COBRA
You have 60 days from the qualifying event or your employer’s notice of the COBRA continuation right, whichever is later, to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

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

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<td>You and your dependents</td>
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</table>

Disability May Increase Maximum Continuation to 29 Months
If You or Your Covered Dependents Are Disabled.

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

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18th month, through the 29th month.

If There Are Multiple Qualifying Events.
A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Premium Payments for Continuation Coverage
Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.
**When You Acquire a Dependent During a Continuation Period**

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent;
- Your employer is notified about your dependent within 31 days of eligibility; and
- Additional premiums for continuation are paid on a timely basis.

**Important Note:**
For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

**When COBRA Continuation Coverage Ends**

Your or your covered dependent 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 or eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.
- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payor Rules or other federal law.
Coordination of Benefits - What Happens When There is More Than One Health Plan

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

Getting Started - Important Terms
When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means any health care expense for any medically necessary health care service or supply, 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. This plan limits coordination of health care services or expenses with those services or expenses that are covered under similar types of plans, (for example, medical coverage is coordinated with another medical plan). An expense or service that is not covered by any of the plans is not an allowable expense. In addition, where Medicare (Part A, B, C or D) is primary, Medicare's allowable expense shall be used as the allowable expense. This Plan does not coordinate benefits for Prescription Drugs. 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 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.

Claim Determination Period. A calendar year which means the period from January 1 through December 31 of the same year.

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. In cases where a court decree awards more than half of the calendar year’s residential time to one parent without the use of “custodial” terminology, the parent to whom the greater resident time is awarded is considered the custodial parent.

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, individual or blanket disability insurance contracts, and group or individual contracts;
- Closed panel plans or other forms of group or individual coverage;
- The medical care components of long term care contracts, such as skilled nursing care; and
- Medicare or other governmental benefits as permitted by law.

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.

Plan does not include:

- Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;
- Accident only coverage;
- Specified disease or specified accident coverage;
- Limited benefit health coverage as defined by state law;
- School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a “to and from school” basis;
- Benefits provided in long-term care insurance policies for nonmedical services;
- Medicare Supplement policies;
- A state plan under Medicaid;
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan’
- Benefits provided as part of a direct agreement with a direct patient –provider primary care practice’ and
- Automobile insurance policies required by statute to provide medical benefits.

This plan is any part of the policy that provides benefits for health care expenses.
Primary Plan/Secondary Plan. The order of benefit determination rules state whether this Plan is a primary plan or secondary plan as to another plan covering the person.

- When this Plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits. A plan is considered the primary plan if it either has no order of benefit determination rules, or if its rules differ from those permitted by Washington State regulations.
- 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 coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expenses as the secondary plan would have paid if it was a primary plan. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings.

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 contractholder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      i. The parents are married or living together whether or not married;
      ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   B. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child’s health care expenses, but that parent’s spouse does, the plan of the parent’s spouse is the primary plan.
   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      – The plan of the custodial parent;
      – The plan of the spouse of the custodial parent;
      – The plan of the non-custodial parent; and then
      – The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the **primary plan**. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the **secondary plan**. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

5. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, or subscriber longer is primary.

6. If the preceding rules do not determine the **primary plan**, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

### How Coordination of Benefits Work

When this Plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this Plan to pay any allowable expenses, not otherwise paid during the claim determination period.

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

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

The time limit for determining benefits payable under this Plan may not be unreasonably delayed due to the application of COB and may not be less favorable than permitted by law.

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

### Multiple Coverage Under Aetna Plans

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

- The person’s coverage in each capacity under this Plan and the other Aetna plan will be set up as a separate “plan.”
- The order in which various plans will pay benefits will apply to the “plans” set up above and to all other plans.
- This provision will not apply more than once to figure the total benefits payable to the person for each claim under this Plan.
Right To Receive And Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment
Any payment made under another plan may include an amount, which should have been paid under this Plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Notice to Covered Persons
If you are covered by more than one health benefit plan, and you do not know which your primary plan is, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.
When You Have Medicare Coverage

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

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

You are eligible for Medicare if you are:

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

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

Which Plan Pays First

The plan is the primary payor when your coverage for the Plan’s benefits is based on current employment with your employer. The Plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age if the Plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the Plan’s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the Plan meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.
How Coordination With Medicare Works

When the Plan is Primary
The Plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration.

Aetna will calculate the benefits the Plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100% of the total allowable expense.

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

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

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

Right to Receive and Release Required Information
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under this Plan and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.
General Provisions

Type of Coverage

Coverage under this plan is non-occupational. Only non-occupational accidental injuries and non-occupational illnesses are covered. This plan covers charges made for services and supplies only while the person is covered under this plan.

Legal Action

Except with respect to claims that are submitted to independent medical review, no legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims. For claims which are sent for review by an Independent Medical Review Organization no legal action can be brought to recover any benefit after 3 years from the completion of review by the Independent Medical Review Organization.

Confidentiality

Information contained in your medical records and information received from any provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by Aetna when necessary for your care or treatment, the operation of this plan and administration of this Booklet-Certificate, or other activities, as permitted by applicable law. You can obtain a copy of Aetna’s Notice of Information Practices by calling Member Services at the number on the back of the ID card.

Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under this plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of this plan. Additional provisions are described elsewhere in the plan’s Group Policy. If you have any questions about the terms of this plan or about the proper payment of benefits, contact your employer or Aetna.
- Your employer hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued with respect to your coverage.

Assignments

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

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

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

If any fact as to the employer or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the employer or you shall be deemed representations and not warranties. No written statement made by you shall be used by Aetna in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

Aetna’s failure to implement or insist upon compliance with any provision of this policy at any given time or times shall not constitute a waiver of Aetna’s right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability

As to Accident and Health Benefits:

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

- No statement made by the employer or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the employer shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Insurance Fraud

- Insurance fraud occurs when you or the policyholder knowingly and with intent to defraud an insurance company or other person, provide us with false information or files a claim for benefits that contains any material false information or conceals for the purpose of misleading, information concerning any material fact. It is a crime if you, or the policyholder to commit insurance fraud and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and penalties. Aetna shall have the right to use all means available to us to detect, investigate, deter and prosecute those who commit insurance fraud. Aetna shall have the right to pursue all legal remedies if you and/or the policyholder perpetrate insurance fraud.

Rescission of Coverage

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

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

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

You have the right to an internal Appeal with Aetna and/or the right to a third party review conducted by an independent External Review Organization if your coverage under this Booklet-Certificate is rescinded retroactive to its Effective Date.
Subrogation and Right of Reimbursement

As used herein, the term “Third Party”, means any party that is, or may be, or is claimed to be responsible for illness or injuries to you. Such illness or injuries are referred to as “Third Party Injuries.” “Third Party” includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

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

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

By accepting benefits under this plan, you specifically acknowledge Aetna’s right of subrogation. After you have been fully compensated for your loss, Aetna shall be subrogated to your right of recovery against any party for the full cost of all health care benefits provided by this plan and to the fullest extent permitted by law, for expenses incurred due to Third Party Injuries.

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

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

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

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

If benefits are paid by Aetna and Aetna determines you received Workers’ Compensation benefits for the same incident, Aetna has the right to recover as described under the Subrogation and Right of Reimbursement provision. Aetna will exercise its right to recover against you.

The Recovery Rights will be applied even though:
- The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers’ Compensation due to medical or health care is not agreed upon or defined by you or the Workers’ Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this policy, you will notify Aetna of any Workers’ Compensation claim you make, and that you agree to reimburse Aetna as described above.

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

Recovery of Overpayments

Health Coverage
If a benefit payment is made by Aetna, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, Aetna has the right:
- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

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

Reporting of Claims

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

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

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

Payment of Benefits

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

All covered health benefits are payable to you. However, Aetna has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.
Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

When a network provider (network services or supplies) provides care to you or a covered dependent, the network provider will take care of filing claims. However, when you seek care on your own (out-of-network services and supplies), you are responsible for filing your own claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of health care providers, dentists and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Financial Sanctions Exclusions

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

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna’s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use Aetna’s toll free Member Services phone number on your ID card or visit Aetna’s web site at www.aetna.com.
Appeals Procedure

Definitions

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

In Washington State, an adverse benefit determination includes:

- A decision to deny, modify, reduce, or terminate payment for, coverage of, authorization of or provision of health care services or benefits including the admission to or continued stay in a facility; or
- A decision that a service or benefit is not covered for other reasons including, but not limited to, you or your dependents are not eligible for coverage at the time service is provided, benefit maximums under the plan have been reached, or the service or supply is not covered under the plan.

As to medical and prescription drug claims only, an adverse benefit determination also means the termination of your coverage back to the original effective date (rescission) as it applies under any rescission of coverage provision of the Policy or the Booklet-Certificate.

Such adverse benefit determination may be based on:

- Your eligibility for coverage.
- Coverage determinations, including plan limitations or exclusions.
- The results of any Utilization Review activities.
- A decision that the service or supply is experimental or investigational.
- A decision that the service or supply is not medically necessary.

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

Complaint/Grievance: Any oral or written expression of dissatisfaction about quality of care or the operation of the Plan (other than payment issues).

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

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

External Review: A review of an adverse benefit determination or a final adverse benefit determination by an Independent Review Organization/External Review Organization (ERO) assigned by the Office of Insurance Commissioner and made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

Final Adverse Benefit Determination: An adverse benefit determination that has been upheld by Aetna at the exhaustion of the appeals process.

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

Post-Service Claim: Any claim that is not a “Pre-Service Claim.”
**Urgent Care Claim**: Any claim for medical care or treatment in which a delay in treatment could:

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

**Full and Fair Review of Claim Determinations and Appeals**

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

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

**Claim Determinations – Group Health Coverage**

Notice of a claim benefit decision will be provided to you in accordance with the guidelines and timelines provided below. If Aetna makes an adverse benefit determination, written notice will be provided to you, or in the case of a concurrent care claim, to your provider.

**Urgent Care Claims**

Aetna will notify you of an urgent care claim decision as soon as possible, but not later than 24 hours after the claim is made.

If more information is needed to make an urgent care claim decision, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional information. Aetna will notify the claimant within 48 hours of the earlier to occur:

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

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

**Pre-Service Claims**

If no additional information is required Aetna will make a claim determination as soon as possible but not later than 5 calendar days after the claim is made. Aetna will provide notification 2 calendar days after the pre-service claim determination is made. Aetna may determine that an extension is needed because Aetna needs additional information to make a claim determination. Aetna will notify you within 5 calendar days from receipt of a pre-service claim if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide Aetna with the required information. Aetna may determine that an extension is needed because Aetna needs additional information to make a claim determination. Aetna will notify you within 5 calendar days from receipt of a pre-service claim if additional information is needed. The notice of the extension shall specifically describe the required information. You will have 30 calendar days, from the date of the notice, to provide Aetna with the required information. Aetna will provide notification 2 calendar days after the pre-service claim determination is made.

**Post-Service Claims**

If all information necessary to evaluate a claim is provided when the post service claim is received, Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that we need additional information in order to make a claim determination, in which case we may request an extension. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day period. The notice of the extension shall specifically describe the required information. You will have 45 calendar days, from the date of the notice, to provide Aetna with the required information. Aetna will not retrospectively deny coverage for precertified care including precertified prescription drugs, if covered.
Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will notify you of a claim decision for urgent care as soon as possible, but not later than 24 hours, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment. With respect to all other care, Aetna will make a determination within 5 calendar days following a request for a concurrent care claim extension and will provide notification within one day of the determination.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of a claim decision to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal, but in no event will the timeframe for the notification be longer than one day.

If you file an appeal, coverage under the plan will continue for the previously approved course of treatment until a final appeal decision is rendered. During this continuation period, you are responsible for any copayments; coinsurance; and deductibles; that apply to the services; supplies; and treatment; that are rendered in connection with the claim that is under appeal. If Aetna's initial claim decision is upheld in the final appeal decision, you will be responsible for all charges incurred for services; supplies; and treatment; received during this continuation period.

Notification of Adverse Determination and Non-certification

Notifications of claim determinations which include an adverse determination will include the actual reasons for the determination, instructions for obtaining an appeal of the decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination. Notifications of an adverse determination and non-certification are provided to you and the treating health care provider or facility making the claim.

Grievances

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must call or write Member Services within 180 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a notification of receipt of your complaint within 30 calendar days of the receipt of the complaint.

Appeals of Adverse Benefit Determinations

You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for one level of appeal. A final adverse benefit determination notice will provide an option to request an External Review

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

- Your name.
- The Policyholder's name.
- A copy of Aetna's notice of an adverse benefit determination.
- Your reasons for making the appeal.
- Any other information you would like to have considered.

Send your written appeal to Member Services at the address shown on your ID Card or on the notice of adverse benefit determination. Alternatively, you can call in your appeal to Member Services using the toll-free telephone number shown on your ID Card.

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

A review of an appeal of an adverse benefit determination shall be provided by Aetna personnel. They shall not have been involved in making the adverse benefit determination.

Urgent Care Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna shall issue a decision within 24 hours of receipt of the request for an appeal, but in no case longer than 72 hours.

Pre-Service Claims (May Include Concurrent Care Claim Reduction or Termination)
Aetna will review the information and provide you with a notification of receipt of your appeal within 72 hours, and a written response within 14 calendar days of the receipt of the appeal, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your appeal, Aetna will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the appeal. Aetna will not take longer than 30 days to respond to your appeal without your written permission. If the appeal involves an experimental or investigational treatment, Aetna will notify you within 20 days. The notice of the decision will tell you what you need to do to request an external review.

Post-Service Claims
Aetna will review the information and provide you with a notification of receipt of your appeal within 72 hours, and a written response within 14 calendar days of the receipt of the appeal, unless additional information is needed and it cannot be obtained within this period. If additional information is necessary to respond to your appeal, Aetna will notify you within the initial 14 day period and may extend the response time to 30 days from the date of receipt of the appeal. Aetna will not take longer than 30 days to respond to your appeal without your written permission. If the appeal involves an experimental or investigational treatment, Aetna will notify you within 20 days. The notice of the decision will tell you what you need to do to request an external review.

Exhaustion of Process

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

Initiate any:
- Litigation;
- Arbitration; or
- Administrative proceeding;
  regarding an alleged breach of the policy terms by Aetna or any matter within the scope of the Appeals Procedure.

Under certain circumstances you may seek simultaneous review through the internal Appeals Procedure and external review processes these include urgent care claims and situations where you are receiving an ongoing course of treatment. Exhaustion of the applicable process of the Appeal Procedure is not required under these circumstances.

Important Note:
If Aetna does not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services, you are considered to have exhausted the appeal requirements and may proceed with external review or any of the actions mentioned above.

There are limits, though, on what sends a claim or an appeal straight to an external review. Your claim or internal appeal will not go straight to external review if:
- a rule violation was minor and isn't likely to influence a decision or harm you;
- it was for a good cause or was beyond Aetna's control; and
- it was part of an ongoing, good faith exchange between you and Aetna.
External Review

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

• the claim involves medical judgment;
• the care is not necessary or appropriate; or
• a service, supply or treatment is experimental or investigational in nature.

In these situations, you may request an external review if you or your provider disagrees with Aetna’s decision.

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

• You received an adverse benefit determination notice by Aetna, and Aetna did not adhere to all claim determination and appeal requirements of the Federal Department of Health and Human Services.
• You have received a final adverse benefit determination notice of the denial of the claim by Aetna.
• Your claim was denied because Aetna determined that the care was not necessary or appropriate or was experimental or investigational.
• You qualify for a faster review as explained below.

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

You must submit the Request for External Review Form to Aetna within 180 calendar days of the date you received the adverse benefit determination or final adverse benefit determination notice. You also must include a copy of the notice and all other pertinent information that supports your request.

Aetna will contact the ERO according to the requirements of Washington law, that will conduct the review of your claim and not more than the third business day after the date we receive your request for an external review, will forward the required documents, including the material you sent to us to the ERO. Within one day of selecting the ERO, we will notify you of the name of the ERO and its contact information. After the ERO receives its assignment, it will accept additional written information from you for up to five business days. You may request a copy of the material we send, and we may request a copy of any additional material you or your treating provider send to the ERO.

The ERO will select one or more independent clinical reviewers with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna’s contractual documents and plan criteria governing the benefits. You will be notified of the decision of the ERO usually within 30 calendar days of Aetna’s receipt of your request form and all the necessary information.

A faster review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would:

• seriously jeopardize your life or health; or
• jeopardize your ability to regain maximum function; or
• if the adverse benefit determination relates to experimental or investigational treatment, if the physician certifies that the recommended or requested health care service, supply or treatment would be significantly less effective if not promptly initiated.
You may also receive a faster review if the final adverse benefit determination relates to an admission; availability of care; continued stay; or health service for which you received emergency care, but have not been discharged from a facility. Faster reviews are decided within 72 hours after Aetna receives the request.

Aetna will abide by the decision of the ERO, except where Aetna can show conflict of interest, bias or fraud.

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

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

**Wellness and Other Incentives**

We may encourage and incent you to access certain medical services, to use online tools that enhance your coverage and services, and to continue participation as an Aetna member. You and your doctor can talk about these medical services and decide if they are right for you. We may also encourage and incent you in connection with participation in a wellness or health improvement program. Incentives include but are not limited to: modifications to copayment, deductible, or coinsurance amounts; premium discounts or rebates; contributions to a health savings account; fitness center membership reimbursement; merchandise; coupons; gift cards; debit cards; or any combination of thereof. The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health status.
Glossary

In this section, you will find definitions for the words and phrases that appear in bold type throughout the text of this Booklet-Certificate.

A

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.

Approved Treatment Program
A discrete program of chemical dependency treatment provided by a program certified by the Washington State Department of Social and Health Services as meeting standards adopted under RCW 70.96A.

A.R.N.P.
An advanced registered nurse practitioner. If listed in the provider directory as a PCP, you may choose an A.R.N.P. as your PCP. If listed in the provider directory as a Women’s Health Care Specialist, you may directly access an A.R.N.P. for women’s health care, including routine preventive care and obstetrical care

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 health care provider who is a specialist in obstetrics and gynecology.
- Has a health care provider or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to health care providers 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 epistiotomy 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 health care providers 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-Named Prescription Drug**
A U.S. Food and Drug Administration (FDA) approved prescription drug with a proprietary name assigned to it by the manufacturer and so indicated by Medi-Span or similar publication designated by Aetna.

C

**Coinsurance**
Coinsurance is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as “plan coinsurance” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.

**Copayment (Copay)**
The specific dollar amount required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts are specified in the Schedule of Benefits.

**Cosmetic**
Services or supplies that alter, improve or enhance appearance.

**Covered Expenses**
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

**Custodial Care**
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a health care provider 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;
- Adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

**Deductible**
The part of your covered expenses you pay before the plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Schedule of Benefits.
**Dental Emergency**
Any dental condition that:

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

**Dental Provider**
This is:

- Any dentist;
- Group;
- Organization;
- Dental facility; or
- Other institution or person;

that is legally qualified to furnish dental services or supplies.

**Dentist**
A legally qualified dentist, or a health care provider including a denturist licensed to do the dental work he or she performs. A dentist does not include any person who is a member of your family, or a member of your spouse’s family or your domestic partner.

**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 health care provider. 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. For purposes of determining covered expenses, detoxification is considered emergency medical care and does not require precertification regardless of where the services are provided.

**Directory**
A listing of all network providers serving the class of employees to which you belong. The employer will give you a copy of this directory. Network provider information is available through Aetna's online provider directory, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this directory.

**Durable Medical and Surgical Equipment (DME)**
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.
Important Reminder: Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

E-visit
A telephone or internet-based consult with a provider that has contracted with Aetna to offer these services.

Emergency Admission
An admission to a hospital or residential treatment facility by a health care provider who admits you right after the sudden and, at that time, unexpected onset of an emergency medical condition, which requires confinement right away as a full-time inpatient.

Emergency Care
This means the treatment given in a hospital's emergency room to evaluate, stabilize and treat an emergency medical condition. Detoxification is considered emergency care.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

G

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

Health Care Provider
This means a health professional, including but not limited to a health care provider, an A. R. N. P., licensed mid-wife, or a health care provider’s assistant who:

- Is properly licensed or certified to provide medical care under the laws of the State of Washington;
- Provides medical services which are within the scope of his or her license or certificate; and
- Has the medical training and clinical expertise suitable to treat your condition.

A health care provider does not include any person who is a member of your family, or a member of your spouse’s family or your domestic partner.

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

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

Important Reminder:
Situations where you would not be considered homebound include (but are not limited to) the following:
- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one health care provider and one R.N.) which makes policy.
- Has full-time supervision by a health care provider 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 health care provider; 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:
  - **Health care provider** 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 **health care provider**;
  - 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 health care providers, 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 health care provider 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 health care providers other than those who own or direct the facility.
- Is run by a staff of health care providers. At least one staff health care provider 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 health care providers;
- Provides twenty-four (24) hour-a-day R.N. service;
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.
In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

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

**I**

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

**Infertile or Infertility**
A disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (or 6 months for women age 35 or older).

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

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place.

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

**J**

**Jaw Joint Disorder**
This is:

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

**L**

**L.P.N.**
A licensed practical or vocational nurse. For purposes of determining covered expenses for home health, hospice or skilled nursing services an L.P.N. does not include any person who resides in your home; or who is a member of your family, or a member of your spouse’s family or your domestic partner.
Mail Order Pharmacy
An establishment where prescription drugs are legally given out by mail or other carrier.

Maintenance Care
Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit
The maximum-out-of-pocket limit is the maximum amount you are responsible to pay for covered expenses during the calendar year. Your deductibles, coinsurance, copayments and other eligible out-of-pocket expenses apply to the maximum out-of-pocket limit.

Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or prescription drugs that we determine a health care provider, or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

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

The provision of the service, supply or prescription drug must as we determine, be:

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

Generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with the standards set forth in policy issues involving clinical judgment.

Mental Disorder
Mental disorders are the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A mental disorder includes; but is not limited to:

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

Mental disorders do not include:
- Substance related disorders; or
- Life transition problems, currently referred to as “V” codes and diagnostic codes 302 through 302.9.

Treatment of mental disorders does not include:
- Court ordered treatment unless the insurer’s medical director or designee determines the treatment to be medically necessary;
- Specific treatment methods listed in the Exclusions and Limitations section; or
- Custodial care.

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

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

Negotiated Charge
As to Health Expense Coverage, (other than Prescription Drug Expense Coverage):
The negotiated charge is the maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:
The negotiated charge is the amount Aetna has established for each prescription drug obtained from a network pharmacy under this plan. This negotiated charge may reflect amounts Aetna has agreed to pay directly to the network pharmacy or to a third party vendor for the prescription drug, and may include an additional service or risk charge set by Aetna.

The negotiated charge does not include or reflect any amount Aetna, an affiliate, or a third party vendor, may receive under a rebate arrangement between Aetna, an affiliate or a third party vendor and a drug manufacturer for any prescription drug, including prescription drugs on the preferred drug guide.

Based on its overall drug purchasing, Aetna may receive rebates from the manufacturers of prescription drugs and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the negotiated charge under this plan.

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

Network Provider
A health care provider, pharmacy or dental provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Aetna’s consent, included in the directory as a network provider for:

- The service or supply involved; and
- The class of employees to which you belong.

Medical network providers are shown in the directory and in DocFind.
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.

Neurodevelopmental Therapy
Speech therapy, physical therapy or occupational therapy given to restore or improve a speech or body function; or to develop a speech or body function delayed by an illness or a congenital abnormality; or to maintain a speech or body function if, without therapy, an illness or congenital abnormality would cause significant deterioration in condition.

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
- A prescription drug or device that is listed on the preferred drug guide.

Non-Specialist
A health care provider who is not a specialist.

Non-Urgent Admission
An inpatient admission that is not an emergency admission or an urgent admission.

Occupational Injury or Occupational Illness
An injury or illness that:

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

Orthodontic Treatment
This is any:

- Medical service or supply; or
- Dental service or supply;
furnished to prevent or to diagnose or to correct a misalignment:

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

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

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

Health care service or supply that is:

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

**Out-of-Network Pharmacy**

A pharmacy that has not contracted with Aetna, an affiliate, or a third party vendor and does not participate in the pharmacy network.

**Out-of-Network Provider**

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

**P**

**Partial Hospitalization Treatment**

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital; psychiatric hospital or residential treatment facility; on less than a full-time inpatient basis.
- It is in line with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a 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 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.
- Is not any person who resides in your home; or who is a member of your family, or a member of your spouse’s family or your domestic partner.
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 "health care provider" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by substance abuse or a mental disorder; and
- A health care provider is not you or related to you.

**Precertification, Precertify, Precertified**

A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable if, for example, it is determined at the time the claim is submitted that you were not eligible for benefits at that time.

**Preferred Drug**

A prescription drug or device that is listed on the preferred drug guide.

**Preferred Drug Guide**

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

**Preferred Drug Guide Exclusions List**

A list of prescription drugs and devices in the preferred drug guide that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna or an affiliate.

**Prescriber**

Any health care provider or dentist, acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

**Prescription**

*As to prescription drugs:*

A written order for the dispensing of a prescription drug by a prescriber. If it is a verbal order, it must promptly be put in writing by the pharmacy.

*As to vision care:*

A written order for the dispensing of prescription lenses or prescription contact lenses by an ophthalmologist or optometrist.

**Prescription Drug**

A drug, biological, or compounded prescription which, by State or Federal Law, may be dispensed only by prescription. This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional.
Primary Care Physician (PCP)
This is the network health care 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, an obstetrician or gynecologist;
- Maintains continuity of patient care; and
- Is shown on Aetna's records as the person's PCP.

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

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

- Mainly provides a program for the diagnosis, evaluation, and treatment of substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a 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
A physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of chemical dependency, or mental disorders.

If treatment of mental disorders or chemical dependency is lawfully provided by a practitioner other than a physician specializing in psychiatry, and if the applicable law of the State of Washington requires recognition of the practitioner for the treatment involved, the practitioner will be considered a psychiatric physician to the extent required by law.

R
Recognized Charge
The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

In all cases, the recognized charge is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For professional services and other services or supplies not mentioned below: 100% of the Medicare Allowable rate
• For services of hospitals and other facilities:
  - 100% of the Medicare Allowable Rate

• For Prescription Drugs:
  - 50% of the Average Wholesale Price, (AWP).

• For dental expenses, the recognized charge for a service or supply is the lesser of:
  - What the provider bills or submits for that service or supply; and
  - the 80th percentile of the Prevailing Charge Rate

The recognized charge is the negotiated charge for providers with whom we have a direct contract but are not network providers.

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

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

Aetna reimbursement policies are based on our review of:

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

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
As used above, Average Wholesale Price (AWP), Geographic Area, Prevailing Charge Rates, and Medicare Allowable Rates are defined as follows:

Average Wholesale Price (AWP)
Is the current average wholesale price of a prescription drug listed in the Facts and Comparisons and Medi-span weekly price updates (or any other similar publication chosen by Aetna).

Geographic Area
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic Area such as an entire state.

Medicare Allowable Rates
Except as specified below, these are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we will determine the rate as follows:

• Use the same method CMS uses to set Medicare rates.
• Look at what other providers charge.
• Look at how much work it takes to perform a service.
• Look at other things as needed to decide what rate is reasonable for a particular service or supply.
Exceptions:

- For inpatient services, our Medicare Allowable Rate excludes amounts CMS allocates for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME). Our rate also excludes other payments which CMS may make directly to hospitals, and for any retroactive adjustments made by CMS.

Prevailing Charge Rates: The percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the Fair Health database becomes unavailable, Aetna has the right to substitute an alternative database that Aetna believes is comparable.

Additional information:

Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

Rehabilitation Facility

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

Rehabilitative Services

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

Residential Treatment Facility (Mental Disorders)

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

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), 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 psychiatric physician 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 and/or education setting.

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

- Is a behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatric physician at least once per week; and
- The medical director must be a psychiatric physician.
Residential Treatment Facility (Substance Abuse)
This is an institution that meets all of the following requirements:

- an approved treatment program;
- Has, on site, licensed behavioral health provider, medical or chemical dependency health care providers 24 hours per day;
- 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 psychiatric physician 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 and/or education 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 health care provider 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 health care provider.

Retail Pharmacy
A community pharmacy which has contracted with Aetna, an affiliate, or a third party vendor, to provide covered outpatient prescription drugs to you.

R.N.
A registered nurse.

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

S

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

The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

The Washington service area is King County.

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 health care provider 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 substance abuse, for developmentally disabled, 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 health care provider who practices in any generally accepted medical or surgical sub-specialty.
Specialty Care
Health care services or supplies that require the services of a specialist.

Specialty Care Prescription Drugs
These are prescription drugs that include injectable, infusion and oral prescription drugs prescribed to address complex, chronic diseases with associated co-morbidities such as:
- Cancer
- Rheumatoid arthritis
- Hemophilia
- Multiple sclerosis

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

Specialty Network Pharmacy
A network of pharmacies designated to fill prescriptions for self-injectable drugs and specialty care prescription drugs.

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

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

Substance Abuse
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your insured dependents.) It is further characterized by a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal. 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. For the purposes of determining covered expenses, chemical dependency is treated as a chronic illness similar to other chronic diseases such as heart disease, diabetes and chronic obstructive pulmonary disease.

Surgery Center
A freestanding ambulatory surgical facility that meets all of the following requirements:
- Is licensed as an ambulatory surgical facility.
- Is set up, equipped and run to provide general surgery.
- Charges for its services and supplies.
- Is directed by a staff of health care providers. 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:
  - Health care providers 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 **health care provider** 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 **health care providers** who do not own or direct the facility.
- Keeps a medical record on each patient.

**T**

**Telemedicine**

A telephone or internet based consult with a **provider** that has contracted with **Aetna** to offer these services. Telemedicine means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email.

**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 **health care provider** 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**

This is:

- A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.
Urgent Condition
This means a sudden illness, injury, or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your health care provider becomes reasonably available.

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities.

Neither of the following should be considered a Walk-in Clinic:
• An emergency room; nor
• The outpatient department of a hospital;
Confidentiality Notice

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

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

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

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

ERISA Rights
As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

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

Continue Group Health Plan Coverage
Note: This sub-section applies to the Plan if your Employer employs 20 or more employees in accordance with a formula mandated by federal law. Check with your Employer to determine if COBRA continuation applies to the Plan.

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

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

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

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

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

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

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

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator.

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

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

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

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

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

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

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

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

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

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

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

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

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

Note: This sub-section applies to the Plan if your Employer employs 50 or more employees as determined by a formula defined by federal law. Check with your Employer to determine if FMLA applies to the Plan.

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If Health Expense Benefits has reduction rules applicable by reason of age or retirement, Health Expense Benefits will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.
Schedule of Benefits
Schedule: WA Silver Polyclinic PPO 2000 80/50 HSA-T

This may or may not be an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

PPO Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductibles:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$2,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$4,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

Important Notes:
Covered expenses that are subject to these deductibles include medical and dental and prescription drug benefits under the plan.

You have a separate deductible that applies for network and out-of-network covered expenses. This means that covered expenses applied to the out-of-network deductible will not be applied to satisfy the network deductible and covered expenses applied to the network deductible will not be applied to satisfy the out-of-network deductible.

All Covered Expenses Are Subject To The Calendar Year Deductibles Unless Otherwise Noted in the Schedule Below.

Plan Maximum Out-of-Pocket Limits

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Maximum Out-of-Pocket Limits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Maximum Out-of-Pocket Limit</td>
<td>$6,450</td>
<td>$19,350</td>
</tr>
<tr>
<td>Family Maximum Out-of-Pocket Limit</td>
<td>$6,450</td>
<td>$38,700</td>
</tr>
</tbody>
</table>

Covered expenses that are subject to the plan maximum out-of-pocket limits include those charges incurred for medical, dental, vision, and prescription drug benefits under the plan.

The Plan Maximum Out-of-Pocket Limits includes deductibles, coinsurance and copayments.

You have a separate maximum out-of-pocket limit for network and out-of-network covered expenses. This means that eligible expenses applied to the out-of-network maximum out-of-pocket limits will not be applied to satisfy the network maximum out-of-pocket limits. Eligible expenses applied to the network maximum out-of-pocket limits will not be applied to satisfy the out-of-network maximum out-of-pocket limits.
Network: Expenses That Do Not Apply to Your Plan Network Maximum Out-of-Pocket Limit
The following expenses do not apply toward your plan network maximum out-of-pocket limit(s):
  - Non-covered expenses

The following expenses do not apply toward your plan out-of-network maximum out-of-pocket limit(s):
  - Charges over the recognized charge;
  - Non-covered expenses;
  - Expenses that are not paid by Aetna, or precertification benefit reductions because a required precertification for the service(s) or supply was not obtained from Aetna.

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount Aetna pays. You are responsible to pay any deductibles, copayments, and the remaining coinsurance. You are responsible for full payment of any non-covered expenses that you incur.

Important Notes: Refer to the Expense Provisions section later in this Schedule of Benefits for more information about copayments, deductibles, coinsurance and maximum out-of-pocket limits.

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

### NETWORK

**Preventive Care**

#### Routine Physical Exams

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
<td>The plan pays 100% per exam</td>
<td>The plan pays 50% per exam after calendar year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons through age 26:</strong> Maximum Age &amp; Visit Limits per calendar year</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your health care provider or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the toll-free number on the back of your ID card.</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your health care provider or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the toll-free number on the back of your ID card.</td>
</tr>
<tr>
<td><strong>Covered Persons ages 27 but less than 65:</strong> Maximum Visits per calendar year</td>
<td>1 visit</td>
<td>1 visit</td>
</tr>
<tr>
<td><strong>Covered Persons age 65 and over:</strong> Maximum Visits per calendar year</td>
<td>1 visit</td>
<td>1 visit</td>
</tr>
</tbody>
</table>

### Preventive Care Immunizations

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The plan pays 100% per visit</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>

**Performed in a facility or health care provider’s office**

Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
## PLAN FEATURES

### Well Woman Preventive Visits

#### Office Visits

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan pays 100% per visit</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Subject to any age or visit limits provided in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
<td>Subject to any age or visit limits provided in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
</tr>
</tbody>
</table>

#### Screening & Counseling Services

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan pays 100% per visit</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Subject to any age or visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
<td>Subject to any age or visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration</td>
</tr>
</tbody>
</table>

### Screening & Counseling Services Maximums INCLUDES NUTRITIONAL COUNSELING

#### Obesity Healthy Diet Counseling

<table>
<thead>
<tr>
<th>Activity</th>
<th>Daily Maximum Visits</th>
<th>Maximum Visits per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and healthy diet counseling</td>
<td>1 visit</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
</tr>
<tr>
<td>Misuse of alcohol and/or drugs</td>
<td>1 visit</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
</tr>
<tr>
<td>Use of tobacco products</td>
<td>1 visit</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
</tr>
<tr>
<td>Sexually transmitted infection counseling</td>
<td>1 visit</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer</td>
<td>1 visit</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infection Counseling:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per calendar year</td>
<td>2 visits*</td>
<td>2 visits*</td>
</tr>
<tr>
<td><strong>Genetic Risk Counseling for Breast and Ovarian Cancer:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per calendar year</td>
<td>Not subject to any age or frequency limitations</td>
<td>Not subject to any age or frequency limitations</td>
</tr>
<tr>
<td><em>Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Cancer Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>The plan pays 100% per test</td>
<td>The plan pays 50% per test after calendar year deductible</td>
</tr>
<tr>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
</tr>
<tr>
<td>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td></td>
</tr>
<tr>
<td>• the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td>• the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>For details, contact your health care provider or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a> or calling the toll-free number on the back of your ID card.</td>
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<td></td>
</tr>
<tr>
<td><strong>Lung Cancer Screening Maximum</strong></td>
<td>1 screening every 12 months*</td>
<td>1 screening every 12 months*</td>
</tr>
<tr>
<td>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Diagnostic and Preoperative Testing section of your Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>The plan pays 100% per visit</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Important Note:</strong> Refer to the Health Care Provider Services, Diagnostic and Preoperative Testing and Pregnancy Expenses sections of this Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PLAN FEATURES

<table>
<thead>
<tr>
<th>Comprehensive Lactation Support and Counseling Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lactation Counseling Services - Facility or Office Visits</strong></td>
</tr>
<tr>
<td>The plan pays 100% per visit No copayment or calendar year deductible applies.</td>
</tr>
<tr>
<td>Lactation Counseling Services Maximum Visits per calendar year either in a group or individual setting</td>
</tr>
</tbody>
</table>

**Important Note:** Visits in excess of the Lactation Counseling Services Maximum Visits, are covered under the *Health Care Provider Services* office visit section of the *Schedule of Benefits*.

<table>
<thead>
<tr>
<th>Breast Feeding Durable Medical Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan pays 100% per item No copayment or calendar year deductible applies.</td>
</tr>
</tbody>
</table>

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

## Family Planning Services - Female Contraceptives

<table>
<thead>
<tr>
<th>Female Contraceptive Counseling Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
</tr>
<tr>
<td>The plan pays 100% per visit No copayment or calendar year deductible applies.</td>
</tr>
<tr>
<td>Contraceptive devices or generic prescription drugs provided by a health care provider during an office visit for female contraceptive counseling</td>
</tr>
<tr>
<td>Female Contraceptive Counseling Services Maximum Visits per calendar year either in a group or individual setting</td>
</tr>
</tbody>
</table>

**Important Note:** Visits in excess of the Female Contraceptive Counseling Services Maximum Visits above, are covered under the *Health Care Provider Services* office visit section of the *Schedule of Benefits*. 
# PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female Voluntary Sterilization</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>The plan pays 100% per admission</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>The plan pays 100% per visit/surgical procedure</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
</tr>
</tbody>
</table>

### Additional Covered Medical Expenses

**Family Planning Services - Other**

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Voluntary Termination of Pregnancy</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The plan pays 80% after calendar year deductible</td>
</tr>
<tr>
<td><strong>Voluntary Sterilization for Males</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>The plan pays 80% after calendar year deductible</td>
</tr>
</tbody>
</table>

### Vision Care Benefits

#### Pediatric Routine Vision Screening and Comprehensive Exams (including refraction, dilation and glaucoma testing) (Coverage is limited to covered persons through the end of the month in which the person turns 19)

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td>The plan pays 100% per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>1 visit</td>
</tr>
</tbody>
</table>

#### Pediatric Vision Care Services and Supplies (Coverage is limited to covered persons through the end of the month in which the person turns 19)

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Office Visit for fitting of eyeglass frames, prescription lenses, low vision devices and contact lenses</em></td>
<td>The plan pays 100% per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>1 visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses</em></td>
<td>The plan pays 100% per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

<table>
<thead>
<tr>
<th>Eyeglass Frames Maximum per calendar year</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One set of eyeglass frames</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Lenses Maximum per calendar year</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One pair of prescription lenses</td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Contact Lenses Maximum per calendar year (includes Non-Conventional Prescription Contact Lenses and Aphakic Lenses Prescribed After Cataract Surgery)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in lieu of eyeglass lenses</td>
<td>1 year supply</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Important Note:* Refer to the Vision Care Benefit in the Booklet-Certificate for the explanation of these vision care supplies.

As to coverage for prescription lenses in a calendar year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

### Physician and Health Care Provider Services

<table>
<thead>
<tr>
<th>Primary Care Physician and other health care providers Office Visits (non-surgical)</th>
<th>The plan pays 80% per visit after calendar year deductible</th>
<th>The plan pays 50% per visit after calendar year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician and other health care providers Office Visits-Surgery</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Primary Care Physician and other health care providers Services for Inpatient Facility and Hospital Visits</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Primary Care Physician and other health care providers Administration of Anesthesia</td>
<td>The plan pays 80% per procedure after calendar year deductible</td>
<td>The plan pays 50% per procedure after calendar year deductible</td>
</tr>
<tr>
<td>Primary Care Physician and other health care providers Administration of Allergy Injections</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td>Primary Care Physician and other health care providers Office Allergy Injections (applies when you do not see the physician)</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td><strong>Specialist Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Physician Office Visits (non-surgical)</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Specialist Physician Office Visits-Surgery</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Specialist-Physician Services for Inpatient Facility and Hospital Visits</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td>Specialist-Physician Administration of Anesthesia</td>
<td>The plan pays 80% per procedure after calendar year deductible</td>
<td>The plan pays 50% per procedure after calendar year deductible</td>
</tr>
<tr>
<td>Specialist-Physician Allergy Testing and Treatment (applies whether you see or do not see the physician)</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Specialist Physician–Administration of Allergy Injections</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Specialist Physician–Office Allergy Injections (applies when you do not see the physician)</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td><strong>Alternatives to Other Health Care Provider Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Walk-In Clinic Visits (Non-Emergency)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Services*</td>
<td>The plan pays 100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Tobacco Use</td>
<td>The plan pays 100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Obesity/Healthy Diet</td>
<td>The plan pays 100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No copayment or calendar year deductible applies.</td>
<td></td>
</tr>
</tbody>
</table>
# PLAN FEATURES

<table>
<thead>
<tr>
<th>Maximum Benefit per visit Individual Screening and Counseling Services for Obesity and Healthy Diet</th>
<th>Refer to the Preventive Care Benefits section earlier in this Schedule of Benefits for maximums that may apply to these types of services.</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

*Important Note:* Not all preventive care services are available at all walk-in clinics. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from a health care provider.

### All Other Services

| The plan pays 80% per visit after calendar year deductible | Not Covered |

### E-Visits and Telemedicine

| Primary Care Physician and Specialist and other Health Care Providers Online Internet and telephonic Consultations | The plan pays 80% per visit after calendar year deductible | Not Covered |

### Hospital Facility Expenses

| Inpatient Services (including maternity) | The plan pays 80% per admission after calendar year deductible | The plan pays 50% per admission after calendar year deductible |
| Outpatient Services (including maternity) | The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |

### Emergency Medical Conditions*

| Hospital Emergency Facility and Health Care Provider | The plan pays 80% per visit after calendar year deductible | The plan pays 80% per visit after calendar year deductible |

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

| Non-Emergency Care in a Hospital Emergency Room | Not Covered | Not Covered |

### Urgent Care Conditions

| Urgent Care Facility (Non-hospital free standing facility) | The plan pays 80% per visit after calendar year deductible applies | The plan pays 50% per visit after calendar year deductible |
| Urgent Care Facility (Other than a non-hospital free standing facility) | Refer to the Emergency Medical Conditions and Health Care Provider Services sections above | Refer to the Emergency Medical Conditions and Health Care Provider Services sections above |
| Non-Urgent Use of Urgent Care Facility (At an Emergency Room or a non-hospital free standing facility) | Not Covered | Not Covered |
### PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
</table>

### Pregnancy Expenses

- **Includes coverage for complications of pregnancy**
  - Covered according to the type of benefit and the place where the service is received.
  - Covered according to the type of benefit and the place where the service is received.

### Birthing Center Facility and Health Care Provider Expenses

- **Facility and Health Care Provider Services**
  - The plan pays 80% per admission after calendar year deductible
  - The plan pays 50% per admission after calendar year deductible

- **Health Care Provider Services - including midwives or nurse midwives**
  - The plan pays 80% per visit after calendar year deductible
  - The plan pays 50% per visit after calendar year deductible

### Alternatives to Hospital Stays

### Outpatient Surgery and Health Care Provider Services

- **Facility Services**
  - Performed at a Hospital Outpatient Facility or Performed at a Surgery Center or Facility other than a Hospital Outpatient Facility
  - The plan pays 80% per visit/surgical procedure after calendar year deductible
  - The plan pays 50% per visit/surgical procedure after calendar year deductible

- **Health Care Provider Services**
  - The plan pays 80% per visit/surgical procedure after calendar year deductible
  - The plan pays 50% per visit/surgical procedure after calendar year deductible

### Home Health Care

- **Outpatient Services including Dialysis**
  - The plan pays 80% per visit after calendar year deductible
  - The plan pays 50% per visit after calendar year deductible

- **Maximum Visits per calendar year**
  - 130 visits

### Skilled Nursing Facility

- **Facility Services**
  - The plan pays 80% per admission after calendar year deductible
  - The plan pays 50% per admission after calendar year deductible

- **Maximum Days per calendar year**
  - 60 days

- **Health Care Provider Services**
  - The plan pays 80% per visit after calendar year deductible
  - The plan pays 50% per visit after calendar year deductible
## PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice Care</strong></td>
<td></td>
</tr>
<tr>
<td>Facility Services</td>
<td>The plan pays 80% per admission after calendar year deductible</td>
</tr>
<tr>
<td><strong>Health Care Provider Services</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Visits</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
</tr>
<tr>
<td><strong>Other Covered Health Care Expenses</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td></td>
</tr>
<tr>
<td>Health Care Provider Services</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>12 visits</td>
</tr>
<tr>
<td>Maximum visits for Substance Abuse per calendar year</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
</tr>
<tr>
<td>Ground Ambulance</td>
<td>The plan pays 80% per trip after calendar year deductible</td>
</tr>
<tr>
<td>Air or Water Ambulance</td>
<td>The plan pays 80% per trip after calendar year deductible</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td>The plan pays 80% per trip after calendar year deductible</td>
</tr>
<tr>
<td><strong>Diagnostic and Preoperative Testing</strong></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Complex Imaging Services</td>
<td>The plan pays 80% per procedure after calendar year deductible</td>
</tr>
<tr>
<td>Outpatient Diagnostic Lab Work</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Diagnostic</strong></td>
<td></td>
</tr>
<tr>
<td>Radiological Services</td>
<td></td>
</tr>
<tr>
<td>Performed at a Hospital</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Outpatient Facility or at a</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Facility other than a Hospital</td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td></td>
</tr>
</tbody>
</table>

| **Outpatient Preoperative Testing** | |
|-------------------------------------||
| Performed at a Hospital             | Covered according to the type of benefit and the place where the service is received. |
| Outpatient Facility or at a         | Covered according to the type of benefit and the place where the service is received. |
| Facility other than a Hospital      |                                                     |
| Outpatient Facility                 |                                                     |

| **Genetic Testing**                | |
|------------------------------------||
| Genetic Testing                    | Covered according to the type of benefit and the place where the service is received. |
|                                    | Covered according to the type of benefit and the place where the service is received. |

| **Durable Medical and Surgical Equipment (DME)** | |
|-------------------------------------------------||
| Durable Medical and Surgical Equipment          | The plan pays 80% per item after calendar year deductible |
|                                                  | The plan pays 50% per item after calendar year deductible |

| **Prosthetic Devices**                      | |
|----------------------------------------------||
| All Prosthetic Devices                       | The plan pays 80% per item after calendar year deductible |
|                                               | The plan pays 50% per item after calendar year deductible |

| **Short Term Cardiac and Pulmonary Rehabilitation Therapy Services** | |
|---------------------------------------------------------------------||
| Cardiac Rehabilitation                                              | The plan pays 80% per visit after calendar year deductible |
|                                                                  | The plan pays 50% per visit after calendar year deductible |
| Pulmonary Rehabilitation                                            | The plan pays 80% per visit after calendar year deductible |
|                                                                  | The plan pays 50% per visit after calendar year deductible |

| **Short Term Rehabilitation and Habilitation Therapy Services**    | |
|--------------------------------------------------------------------||
| Outpatient Habilitation Therapies (Physical, Occupational, Speech and Aural Therapies) (combined) | The plan pays 80% per visit after calendar year deductible |
|                                                                  | The plan pays 50% per visit after calendar year deductible |
| Maximum Visits per calendar year                                   | 25 visits |
| Autism Spectrum Disorders are not subject to this maximum.         | 25 visits |

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<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Rehabilitation, (Physical, Occupational, Speech and Massage Therapies) (combined)</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>25 visits</td>
<td>25 visits</td>
</tr>
<tr>
<td>Autism Spectrum Disorders are not subject to this maximum.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation/Chiropractic Treatment</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>12 visits</td>
<td>12 visits</td>
</tr>
<tr>
<td>Neurodevelopmental Therapy</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
</tr>
<tr>
<td>Maximum Visits per calendar year</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

**Specialized Care**

**Reconstructive or Cosmetic Surgery and Supplies**

Coverage is provided only to the extent as described in the Booklet-Certificate.

The plan pays 80% per visit after calendar year deductible

The plan pays 50% per visit after calendar year deductible

**Reconstructive Breast Surgery**

The plan pays 80% per visit after calendar year deductible

The plan pays 50% per visit after calendar year deductible

**Clinical Trial Therapies (Experimental or Investigational Treatment)**

Clinical trial therapies Coverage is provided only to the extent as described in the Booklet-Certificate.

Covered according to the type of benefit and the place where the service is received.

Covered according to the type of benefit and the place where the service is received.
### PLAN FEATURES | NETWORK | OUT-OF-NETWORK
--- | --- | ---

#### Clinical Trials (Routine Patient Costs)

| Clinical Trials (Routine Patient Costs) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

#### Outpatient Therapies

| Chemotherapy Benefits | The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |
| Radiation Therapy Benefits | The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |
| Infusion Therapy Benefits | The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |

#### Diabetes Benefit

| (Services, Supplies, Equipment and Training) | The plan pays 80% per item/visit after calendar year deductible | The plan pays 50% per item/visit after calendar year deductible |

#### Autism Spectrum Disorders

| Applied Behavioral Analysis | The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |

#### Basic Infertility Expenses

| Coverage is only for the diagnosis and treatment of the underlying medical condition causing the infertility. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

#### Nutritional Supplements

| Nutritional Supplements - Phenylketonuria Treatment, any other Special Medical Formulas | The plan pays 80% per item/prescription after the calendar year deductible | The plan pays 50% per item/prescription after the calendar year deductible |

#### Jaw Joint Disorder Treatment

| Jaw Joint Disorder Treatment | The plan pays 80% per visit after the calendar year deductible | The plan pays 50% per visit after the calendar year deductible |
## PLAN FEATURES

### Transplant Services

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK (IOE Provider Facility)</th>
<th>NETWORK (Non-IOE Provider Facility)</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Facility Expenses</td>
<td>The plan pays 80% per admission after calendar year deductible</td>
<td>The plan pays 50% per admission after calendar year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transplant Physician Services</td>
<td>The plan pays 90% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after calendar year deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Transplant Travel and Lodging Expenses

| Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants | $10,000                                                                 | Not Applicable |
| Maximum Benefit payable for Lodging Expenses per IOE patient                                           | $50 per night                                                          | Not Applicable |
| Maximum Benefit payable for Lodging Expenses per companion and donor                                  | $50 per night                                                          | Not Applicable |

### Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Only covered expenses that are medical in nature

| The plan pays 80% per visit after calendar year deductible | The plan pays 50% per visit after calendar year deductible |

### Treatment of Mental Disorders

#### Inpatient Expenses

<p>| Facility Services                      | The plan pays 80% per admission after the calendar year deductible | The plan pays 50% per admission after the calendar year deductible |
| Health Care Provider Services          | The plan pays 80% per visit after the calendar year deductible   | The plan pays 50% per visit after the calendar year deductible   |</p>
<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Facility and Health Care Provider</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Inpatient Residential Treatment</td>
<td>The plan pays 80% per admission after the calendar year deductible</td>
<td>The plan pays 50% per admission after the calendar year deductible</td>
</tr>
<tr>
<td>Facility Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Health Care Provider Services</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td><strong>Treatment of Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td>The plan pays 80% per admission after the calendar year deductible</td>
<td>The plan pays 50% per admission after the calendar year deductible</td>
</tr>
<tr>
<td>**Health Care Provider Services</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Facility and Health Care Provider</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
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</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Inpatient Residential Treatment</td>
<td>The plan pays 80% per admission after the calendar year deductible</td>
<td>The plan pays 50% per admission after the calendar year deductible</td>
</tr>
<tr>
<td>Facility Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Health Care Provider Services</td>
<td>The plan pays 80% per visit after the calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
</tbody>
</table>
## PLAN FEATURES | NETWORK | OUT-OF-NETWORK
--- | --- | ---

### All Other Covered Expenses

<table>
<thead>
<tr>
<th>Covered expense</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Products</td>
<td>The plan pays 80% per visit after calendar year deductible</td>
<td>The plan pays 50% per visit after the calendar year deductible</td>
</tr>
<tr>
<td>Covered expenses not specifically mentioned above.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Pediatric Dental Services

(Coverage is limited to covered persons through the end of the month in which the person turns 19)

<table>
<thead>
<tr>
<th>Type</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A Expenses</td>
<td>The plan pays 100% after the calendar year deductible</td>
<td>The plan pays 70% after the calendar year deductible</td>
</tr>
<tr>
<td>Type B Expenses</td>
<td>The plan pays 70% after the calendar year deductible</td>
<td>The plan pays 50% after the calendar year deductible</td>
</tr>
<tr>
<td>Type C Expenses</td>
<td>The plan pays 50% after the calendar year deductible</td>
<td>The plan pays 50% after the calendar year deductible</td>
</tr>
<tr>
<td>Orthodontic Expenses</td>
<td>The plan pays 50% after the calendar year deductible</td>
<td>The plan pays 50% after the calendar year deductible</td>
</tr>
</tbody>
</table>

### Dental Emergency Maximum Benefit:

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Applicable</td>
<td>$75</td>
</tr>
</tbody>
</table>

The most the plan will pay for covered expenses incurred by a covered person for any one Dental Emergency is called the Dental Emergency Maximum Benefit.

Dental expenses are subject to the plan’s deductibles and maximum out-of-pocket limits as explained on the Schedule of Benefits.
Pharmacy Benefit

Important Note
Refer to Your Pharmacy Benefit and to What the Pharmacy Benefit Covers sections in the Booklet-Certificate for details about your outpatient prescription drug coverage.

- The Schedule of Benefits details your cost sharing.
- You may pay less for prescriptions if you:
  - Use generic, prescription drugs rather than brand name prescription drugs;
  - Obtain prescription drugs from network pharmacies rather than out-of-network pharmacies;
  - Use prescription drugs that are on the preferred drug guide (formulary);
  - Obtain injectable, self-injectable drugs, or specialty care prescription drugs from a specialty network pharmacy or network pharmacies;
  - Use a mail order pharmacy that is a network pharmacy after your initial refill.
- Precertification and step therapy for certain prescription drugs is required. If precertification is not obtained, the prescription drug will not be covered.

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription preferred generic copay and calendar year deductible will not apply to risk-reducing breast cancer preferred generic prescription drugs when obtained at a network pharmacy. This means that such prescriptions will be paid at 100%.

Deductible and Copayment/Coinsurance Waiver for Tobacco Cessation Prescription and Over-the-Counter Drugs

The calendar year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens for tobacco cessation prescription drugs and OTC drugs when obtained at a retail network pharmacy. This means that such prescription drugs and OTC drugs will be paid at 100%. Your calendar year deductible and any prescription copayment/coinsurance will apply after those two regimens have been exhausted.

Female Contraceptives - Copayment and Deductible Waiver

Waiver for Prescription Drug Contraceptives

The per prescription preferred generic copayment and calendar year deductible will not apply to female contraceptive methods when obtained at a network pharmacy. This means that such contraceptive methods will be paid at 100% for:

- Female oral and injectable contraceptives that are preferred generic prescription drugs:
  - Oral drugs
  - Injectable drugs
  - Vaginal rings
  - Transdermal contraceptive patches
- Female contraceptive devices that are generic devices and brand-name devices
- FDA approved female:
  - Preferred generic and brand emergency contraceptives
  - Preferred generic and brand over-the-counter (OTC) emergency contraceptives
- Other FDA approved female generic over-the-counter (OTC) contraceptives.

The per prescription brand copayment will continue to apply to brand prescription drug contraceptives that have a generic equivalent or generic alternative available within the same therapeutic drug class obtained at a network pharmacy unless you are granted a medical exception.
## Family Planning Services - Female Contraceptives

| Female contraceptives that are **preferred generic prescription drugs**  
For each 30 day supply filled at a retail pharmacy:  
- Oral drugs  
- Injectable drugs  
- Vaginal rings*  
- Transdermal contraceptive patches | The plan pays 100% per prescription or refill  
No copayment or calendar year deductible applies. | Not Covered |
|---|---|---|

| Female contraceptives that are **Brand-Name Prescription Drugs**. For each 30 day supply:  
- Oral drugs  
- Injectable drugs  
- Vaginal rings*  
- Transdermal contraceptive patches | Paid according to the tier of drug per the Schedule of Benefits, below  
*Brand-name vaginal rings covered at 100% to the extent that a generic is not available | Not Covered |
|---|---|---|

| Female contraceptive generic and brand name devices  
For each 30 day supply filled at a retail pharmacy | The plan pays 100% per prescription or refill  
No copayment or calendar year deductible applies. | Not Covered |
|---|---|---|

| FDA-approved female generic and brand over-the-counter (OTC) emergency contraceptives For each 30 day supply filled at a retail pharmacy | The plan pays 100% per prescription or refill  
No copayment or calendar year deductible applies. | Not Covered |
|---|---|---|

| Maximum emergency contraceptives per month. This maximum is a combined maximum for over-the-counter emergency contraceptives and emergency contraceptives | 1 | Not Covered |
| Other FDA-approved female generic and brand over-the-counter (OTC) contraceptives. For each 30 day supply filled at a retail pharmacy | The plan pays 100% per **prescription** or refill  
No copayment or **calendar year deductible** applies. | Not Covered |
| Maximum OTC contraceptives. | 1 OTC contraceptive per day and a 30 day supply per prescription | Not Covered |

**Preventive Care Drugs and Supplements**

| Preventive care drugs and supplements filled at a retail **pharmacy** For each 30 day supply | The plan pays 100% per **prescription** or refill  
No copayment or **calendar year deductible** applies. | Not Covered |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card. | Not Covered |
### Tobacco Cessation Prescription and Over-the-Counter Drugs

<table>
<thead>
<tr>
<th>Tobacco cessation <strong>prescription drugs</strong> and OTC drugs filled at a <strong>pharmacy</strong></th>
<th>The plan pays 100% per <strong>prescription</strong> or refill</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30-day supply</td>
<td>No <strong>copayment</strong> or <strong>calendar year deductible</strong> applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Maximums:</strong> Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation <strong>prescription drugs</strong> and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Risk Reducing Breast Cancer Prescription Drugs

<table>
<thead>
<tr>
<th>For each 30-day supply filled at a <strong>retail pharmacy</strong></th>
<th>The plan pays 100% per <strong>prescription</strong> or refill</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximums:</strong> Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer <strong>Prescription Drugs</strong>, contact Member Services by logging onto the Aetna Navigator® secure member website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the number on the back of your ID card.</td>
<td>No <strong>copayment</strong> or <strong>calendar year deductible</strong> applies.</td>
<td></td>
</tr>
</tbody>
</table>
PHARMACY BENEFIT

PER PRESCRIPTION COPAYMENTS

*Preferred Generic Prescription Drugs*

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply filled at a retail pharmacy</td>
<td>$10 per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For all fills of at least 30 days but no more than a 90 day supply filled at a mail order pharmacy</td>
<td>$20 per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Preferred Brand-Name Prescription Drugs*

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply filled at a retail pharmacy</td>
<td>$50 per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For all fills of at least 30 days but no more than a 90 day supply filled at a mail order pharmacy</td>
<td>$100 per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Non-Preferred Generic and Brand Name Prescription Drugs*

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply filled at a retail pharmacy</td>
<td>The plan pays 70% of the negotiated charge per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For all fills of at least 30 days but no more than a 90 day supply filled at a mail order pharmacy</td>
<td>The plan pays 70% of the negotiated charge per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*Preferred and Non-Preferred Specialty Care Prescription Drugs*

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each:</td>
<td>The plan pays 70% of the negotiated charge per prescription after calendar year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Initial 30 day supply at a retail pharmacy or specialty care network pharmacy; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 30 day refill at a specialty network pharmacy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Diabetic Prescription Drugs, Supplies and Insulin*

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply filled at a retail pharmacy</td>
<td>Paid according to the tier of drug per the Schedule of Benefits, above.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>For all fills of at least 30 days but no more than a 90 day supply filled at a mail order pharmacy</td>
<td>Paid according to the tier of drug per the Schedule of Benefits, above.</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

If you or your prescriber request a covered brand-name prescription drug where a covered generic prescription drug equivalent is available you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug equivalent, plus the applicable cost sharing.
Expense Provisions

The following provisions apply to your health expense plan.

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

Deductible Provisions

Covered expenses that are subject to the deductibles include those charges incurred for medical, dental, and prescription drugs benefits.

Individual Network Calendar Year Deductible
The individual deductible is the amount of covered expenses for network services and supplies you must incur in a calendar year before benefits are paid. For purposes of this plan, an individual means a single covered person enrolled for self only coverage. Covered expenses applied to the out-of-network individual calendar year deductible will not be applied to satisfy this network individual calendar year deductible.

Individual Out-of-Network Calendar Year Deductible
The individual deductible is the amount of covered expenses for out-of-network services and supplies you must incur in a calendar year before benefits are paid. For purposes of this plan, an individual means a single covered person enrolled for self only coverage. Covered expenses applied to the network individual calendar year deductible will not be applied to satisfy this out-of-network individual calendar year deductible.

Family Network Calendar Year Deductible
This is the amount of covered expenses for network services and supplies that you and your covered dependents must incur in a calendar year before benefits are paid for any family members. For purposes of this plan, a family means a covered person enrolled with one or more dependents. The family deductible can be met by one family member, or a combination of family members. Covered expenses applied to the out-of-network family calendar year deductible will not be applied to satisfy this network family calendar year deductible.

Family Out-of-Network Calendar Year Deductible
This is the amount of covered expenses for out-of-network services and supplies that you and your covered dependents must incur in a calendar year before benefits are paid for any family members. For purposes of this plan, a family means a covered person enrolled with one or more dependents. The family deductible can be met by one family member, or a combination of family members. Covered expenses applied to the network family calendar year deductible will not be applied to satisfy this out-of-network family calendar year deductible.

Copayment Provision

Copayment, Copay
This is a specified dollar amount required to be paid by you at the time you receive a covered service from a provider.
Coinsurance Provisions

Coinsurance
This is the percentage of your covered expenses that the plan pays and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the “Plan Coinsurance”. Once applicable deductibles have been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The coinsurance percentage may vary by the type of expense.

For purposes of the following maximum out-of-pocket limits, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents.

Network Maximum Out-of-Pocket Limits
Covered expenses that are subject to the maximum out-of-pocket limits include those charges incurred for medical, dental, prescription drug, and vision benefits.

The maximum out-of-pocket limit is the maximum amount you are responsible to pay for network covered expenses during the calendar year. This plan has an individual and family maximum out-of-pocket limit.

Individual
Once the amount of eligible expenses for network services and supplies you have paid during the calendar year meets the individual maximum out-of-pocket limit, this plan will pay 100% of covered expenses for network services and supplies that apply toward the limit for the remainder of the calendar year for that person.

Family
The family maximum out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the amount of eligible expenses for network services and supplies paid during the calendar year meets this family maximum out-of-pocket limit, this plan will pay 100% of covered expenses for network services and supplies that apply toward the limit for the remainder of the calendar year for all covered family members.

Out-of-Network Maximum Out-of-Pocket Limit
Covered expenses that are subject to the maximum out-of-pocket limits include those charges incurred for medical, dental, prescription drug, and vision benefits.

The maximum out-of-pocket limit is the maximum amount you are responsible to pay for out-of-network covered expenses during the calendar year. This plan has an individual and family maximum out-of-pocket limit.

Individual
Once the amount of eligible expenses for out-of-network services and supplies you have paid during the calendar year meets the individual maximum out-of-pocket limit, this Plan will pay 100% of covered expenses for out-of-network services and supplies that apply toward the limit for the remainder of the calendar year for that person.

Family
The family maximum out-of-pocket limit can be met by a combination of family members or by any single individual within the family. Once the amount of eligible expenses for out-of-network services and supplies paid during the calendar year meets this family maximum out-of-pocket limit, this Plan will pay 100% of covered expenses for out-of-network services and supplies that apply toward the limit for the remainder of the calendar year for all covered family members.
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. In the event a network hospital has only private rooms, the covered expenses will equal the negotiated charge. For out of network hospital covered expenses are based on the recognized charge.

Precertification Benefit Reduction
The Booklet-Certificate contains complete descriptions of the precertification programs for medical and prescription drug benefits. For medical benefits, refer to the “Understanding Medical Precertification” section for a list of services and supplies that require precertification. For prescription drug benefits, refer to the “Understanding Pharmacy Precertification” section.

Failure to precertify your covered expenses for certain medical services when required will result in a precertification benefits reduction as follows:
- A $400 penalty will be applied separately to each type of expense. However, the penalty amount will not exceed 50% of the recognized charge for each type of expense.

Precertification and step therapy for certain prescription drugs is required. If precertification is not obtained, the prescription drug will not be covered.

General
This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. Coverage is underwritten by Aetna Life Insurance Company.

The insurance described in this Schedule of Benefits will be provided under Aetna Life Insurance Company's Policy form OFFHIXHSATGR-96791

Keep This Schedule of Benefits With Your Booklet-Certificate.