BENEFIT PLAN

Prepared Exclusively for
University of Hartford

Choice POS II Medical Plan

What Your Plan
Covers and How
Benefits are Paid
Choice POS II Medical Plan

Booklet

Prepared exclusively for:

Employer: University of Hartford
Contract number: 724328
Booklet 1
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Third Party Administrative Services provided by Aetna Life Insurance Company
Welcome

Thank you for choosing Aetna.

This is your booklet. It is one of two documents that together describe the benefits covered by your Employer’s self-funded health benefit plan for in-network and out-of-network coverage.

This booklet will tell you about your covered benefits – what they are and how you get them. It takes the place of all booklets describing similar coverage that were previously sent to you. The second document is the schedule of benefits. It tells you how we share expenses for eligible health services and tells you about limits – like when your plan covers only a certain number of visits.

Each of these documents may have amendments attached to them. They change or add to the documents they’re part of.

Where to next? Flip through the table of contents or try the Let’s get started! section right after it. The Let’s get started! section gives you a thumbnail sketch of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your Employer’s self-funded health benefit plan for in-network and out-of-network coverage.
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Let’s get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words

- When we say “you” and “your”, we mean both you and any covered dependents.
- When we say “us”, “we”, and “our”, we mean Aetna when we are describing administrative services provided by Aetna as Third Party Administrator.
- Some words appear in bold type. We define them in the Glossary section.

Sometimes we use technical medical language that is familiar to medical providers.

What your plan does – covered benefits

Your plan provides covered benefits. These are eligible health services for which your plan has the obligation to pay.

This plan provides in-network and out-of network coverage for medical, vision and pharmacy benefits.

What your plan doesn’t do – exclusions

Your plan does not pay for benefits that are not covered under the terms of the plan. These are Exclusions and are described in greater detail later in the document.

Many health care services and supplies are eligible for coverage under your plan in the Eligible health services under your plan section. However, some of those health care services and supplies have exclusions. For example, physician care is an eligible health service, but physician care for cosmetic surgery is never covered. This is an example of an exclusion.

The What your plan doesn’t cover - some eligible health service exclusions section of this document also provides additional information.

The Plan does not cover any payments that are prohibited by the Federal Office of Foreign Asset Control.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after you complete the eligibility and enrollment process. To learn more see the Who the plan covers section.

Your coverage typically ends when you leave your job. Family members can lose coverage for many reasons, such as growing up and leaving home. To learn more see the When coverage ends section.

Ending coverage under the plan doesn’t necessarily mean you lose coverage with us. See the Special coverage options after your plan coverage ends section.
How your plan works while you are covered in-network

Your in-network coverage:

- Helps you get and pay for a lot of – but not all – health care services. These are called eligible health services.
- You will pay less cost share when you use a network provider.

1. Eligible health services
   So what are eligible health services? They are health care services that meet these three requirements:
   - They are listed in the Eligible health services under your plan section.
   - They are not carved out in the What your plan doesn’t cover – some eligible health service exclusions section. (We refer to this section as the “exclusions” section.)
   - They are not beyond any limits in the schedule of benefits.

2. Providers
   Aetna’s network of doctors, hospitals and other health care providers are there to give you the care you need. You can find network providers and see important information about them most easily on our online provider directory. Just log into your Aetna Navigator® secure member website at www.aetna.com.

   You may choose a primary care physician (we call that doctor your PCP) to oversee your care. Your PCP will provide your routine care, and send you to other providers when you need specialized care. You don’t have to access care through your PCP. You may go directly to network specialists and providers for eligible health services. Your plan often will pay a bigger share for eligible health services that you get through your PCP, so choose a PCP as soon as you can.

   For more information about the network and the role of your PCP, see the Who provides the care section.

3. Paying for eligible health services– the general requirements
   There are several general requirements for the plan to pay any part of the expense for an eligible health service. They are:
   - The eligible health service is medically necessary.
   - You get the eligible health service from a network or out-of-network provider.
   - You or your provider precertifies the eligible health service when required.

   You will find details on medical necessity and precertification requirements in the Medical necessity and precertification requirements section.

4. Paying for eligible health services– sharing the expense
   Generally your plan and you will share the expense of your eligible health services when you meet the general requirements for paying.

   But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the What the plan pays and what you pay section, and see the schedule of benefits.
5. **Disagreements**
   We know that people sometimes see things differently.

   The plan tells you how we will work through our differences. And if we still disagree, an independent group of experts called an “external review organization” or ERO for short, will make the final decision for us.

   For more information see the *When you disagree - claim decisions and appeals procedures* section.

**How your plan works while you are covered out-of-network**

The section above told you how your plan works while you are covered in-network. You also have coverage when you want to get your care from providers who are not part of the Aetna network. It’s called out-of-network or other health care coverage.

Your out-of-network coverage:

- Means you can get care from providers who are not part of the Aetna network.
- Means you will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of eligible health services that you paid directly to a provider.
- Means that when you use out-of-network coverage, it is your responsibility to start the precertification process with providers.
- Means you will pay a higher cost share when you use an out-of-network provider.

You will find details on:

- **Precertification** requirements in the *Medical necessity and precertification requirements* section.
- **Out-of-network providers** and any exceptions in the *Who provides the care* section.
- Cost sharing in the *What the plan pays and what you pay* section, and your schedule of benefits.
- Claim information in the *When you disagree - claim decisions and appeals procedures* section.

**How to contact us for help**

We are here to answer your questions. Your plan of benefits includes the Aetna Concierge program. The program provides immediate access to healthcare resource consultants who have been specifically trained in the details of your plan. To contact an Aetna Concierge for questions on your plan, wherever you see the term Member Services within this booklet-certificate or your schedule of benefits, this is your Aetna Concierge team.

Register for Aetna Navigator®, our secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

You can contact us by:

- Calling your Aetna Concierge at 866-275-9086 on your ID card from 8:00 a.m. to 6:00 p.m. Monday through Friday
- Logging onto Aetna Navigator® at [www.aetna.com](http://www.aetna.com)
Your member ID card

Your member ID card tells doctors, hospitals, and other providers that you are covered by this plan. Show your ID card each time you get health care from a provider to help them bill us correctly and help us better process their claims.

Remember, only you and your covered dependents can use your member ID card. If you misuse your card we may end your coverage.

We will mail you your ID card. If you haven’t received it before you need eligible health services, or if you’ve lost it, you can print a temporary ID card. Just log into your Aetna Navigator® secure member website at www.aetna.com.
Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

You are eligible to enroll in the Plan if you are a regular full-time employee, a regular part-time employee who is scheduled to work at least 20 hours per week for at least 40 weeks per year; a qualified temporary employee who works an average of 30 or more hours per week totaling 1,500 hours per year, or a person who retires while covered under the Plan, who is under the age of 65 and meets the University’s definition of a qualified retiree. Your eligible dependents may also participate in the Plan.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- At the end of any waiting period your Employer requires
- Once each Calendar Year during the annual enrollment period
- At other special times during the year (see the Special times you and your dependents can join the plan section below)

If you do not enroll yourself and your dependents when you first qualify for health benefits, you may have to wait until the next annual enrollment period to join. If you experience a qualifying event, it is imperative that you notify HRD within 30 days of a qualifying event. Based on IRS regulations, this 30-day time period provides employees with a special enrollment period in which to make applicable insurance benefit election changes.

Failure to notify HRD within 30 days of a qualifying event will result in loss of eligibility to make applicable insurance election changes as well as loss of eligibility for continuation of applicable insurance coverages under federal COBRA law and/or plan guidelines. In these instances, the employee must then wait until the University’s next annual open enrollment period (which occurs every fall) to make insurance election changes.

Who can be on your plan (who can be your dependent)

An eligible dependent is considered to be:

- Your eligible spouse:
  - definition of an eligible spouse* as it relates to the University’s medical insurance plans as follows:
    - Eligible Spouse – an employee’s spouse who does not have access to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act) through his/her employer.
    - Ineligible Spouse – an employee’s spouse who has access to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act) through his/her employer.

* Employees whose base earnings are less than $40,000, if annualized, are exempt from this requirement, if applicable.
• Your dependent children – your own or those of your spouse
  - The children must be under 26 years of age, and they include your:
    o Biological children
    o Stepchildren
    o Legally adopted children, including any children placed with you for adoption or a child for whom you or your eligible spouse are the legal guardian
    o Children you are responsible for under a qualified medical support order or court-order (whether or not the child resides with you)
    o An unmarried child age 26 or over who is or becomes disabled and dependent upon you

You may continue coverage for a disabled child past the age limit shown above. See the Continuation of coverage for other reasons in the Special coverage options after your plan coverage ends section for more information.

Adding new dependents
You can add the following new dependents any time during the year: with a qualifying event.
• A spouse - If you marry, you can put your spouse on your plan.
  - Your Employer must receive your completed enrollment information not more than 31 days after the date of your marriage.
  - Ask your Employer when benefits for your spouse will begin. It will be: benefits begin the date of marriage.
• A newborn child - Your newborn child is covered on your health plan for the first 31 days after birth.
  - To keep your newborn covered, your Employer must receive your completed enrollment information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional contribution for the covered dependent.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
• An adopted child - A child that you, or that you and your spouse adopts is covered on your plan for the first 31 days after the adoption is complete.
  - To keep your adopted child covered, your Employer must receive your completed enrollment information within 31 days after the adoption.
  - If you miss this deadline, your adopted child will not have health benefits after the first 31 days.
• A stepchild - You may put a child of your spouse on your plan.
  - You must complete your enrollment information and send it to your Employer within 31 days after the date of your marriage with your stepchild’s parent.
  - Ask your Employer when benefits for your stepchild will begin. It is either on the date of your marriage or the first day of the month following the date we receive your completed enrollment information.

Notification of change in status
It is important that you notify your Employer of any changes in your benefit status within 31 days of the date of the event. This will help your Employer effectively maintain your benefit status. Please notify your Employer as soon as possible of status changes such as:
• Change of address
• Change of covered dependent status
• Enrollment in Medicare or any other group health plan of any covered dependent
Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another group health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your contribution for coverage under this plan.
- When a court orders that you cover a current spouse or a minor child on your health plan.

Your Employer or the party they designate must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage
Claims will not be paid under any health benefits for expenses incurred in connection with any hospital stay that began before the date you or your dependents became covered.
Medical necessity and precertification requirements

The starting point for covered benefits under your plan is whether the services and supplies are eligible health services. See the Eligible health services under your plan and exclusions sections plus the schedule of benefits.

Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is medically necessary.
- You or your provider precertifies the eligible health service when required.

This section addresses the medical necessity and precertification requirements.

Medically necessary; medical necessity
As we said in the Let’s get started! section, medical necessity is a requirement for you to receive a covered benefit under this plan.

The medical necessity requirements are stated in the Glossary section, where we define "medically necessary, medical necessity". That is where we also explain what our medical directors or their physician designees consider when determining if an eligible health service is medically necessary.

Precertification
You need pre-approval from us for some eligible health services. Pre-approval is also called precertification.

In-network: your physician is responsible for obtaining any necessary precertification before you get the care. If your physician doesn't get a required precertification, we won’t pay the provider who gives you the care. You won't have to pay either if your physician fails to ask us for precertification. If your physician requests precertification and we refuse it, you can still get the care but the plan won’t pay for it. You will find details on requirements in the What the plan pays and what you pay - Important exceptions – when you pay all section.

Out-of-network: when you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section. Also, for any precertification benefit reduction that is applied see the schedule of benefits Precertification benefit reduction section.

When it is a life-threatening emergency, call 911 or go straight to the nearest emergency room. If admitted, precertification should be secured within the timeframes specified below. To obtain precertification, call us at the telephone number listed on your ID card. This call must be made:

<table>
<thead>
<tr>
<th>For non-emergency admissions:</th>
<th>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For an emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission:</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis</td>
</tr>
</tbody>
</table>
We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

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

If precertification determines that the stay or services and supplies are not covered benefits, the notification will explain why and how our decision can be appealed. You or your provider may request a review of the precertification decision. See the Claim decisions and appeals procedures section.

What if you don’t obtain the required precertification?
If you don’t obtain the required precertification:
- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits Precertification benefit reduction section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network deductibles or maximum out-of-pocket limits.

What types of services require precertification?
Precertification is required for the following types of services and supplies:

<table>
<thead>
<tr>
<th>Inpatient services and supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays in a hospital</td>
</tr>
<tr>
<td>Stays in a skilled nursing facility</td>
</tr>
<tr>
<td>Stays in a rehabilitation facility</td>
</tr>
<tr>
<td>Stays in a hospice facility</td>
</tr>
<tr>
<td>Stays in a residential treatment facility for treatment of mental disorders and substance abuse</td>
</tr>
<tr>
<td>ART services</td>
</tr>
<tr>
<td>Comprehensive infertility services</td>
</tr>
<tr>
<td>Cosmetic and reconstructive surgery</td>
</tr>
</tbody>
</table>

Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility and not obtained at a pharmacy. The following precertification information applies to these prescription drugs:

For certain drugs, your prescriber or your pharmacist needs to get approval from us before we will agree to cover the drug for you. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs and makes sure there is a medically necessary need for the drug. For the most up-to-date information, call the toll-free Concierge number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.
There is another type of precertification for prescription drugs, and that is step therapy. Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

You can obtain the most up-to-date information about step therapy 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. Your doctor can find additional details about the step therapy prescription drugs in our clinical policy bulletins.

Sometimes you or your prescriber may seek a medical exception to get health care services for drugs not covered or for which health care services are denied through precertification and/or step therapy. You or your prescriber can contact us and will need to provide us with the required clinical documentation. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case determination, and will not apply or extend to other covered persons.
Eligible health services under your plan

The information in this section is the first step to understanding your plan's eligible health services.

Your plan covers many kinds of health care services and supplies, such as physician care and hospital stays. But sometimes those services are not covered at all or are covered only up to a limit.

For example,

- Physician care generally is covered but physician care for cosmetic surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a covered benefit only up to a set number of visits a year. This is a limitation.

You can find out about these exclusions in the exclusions section, and about the limitations in the schedule of benefits.

We've grouped the health care services below to make it easier for you to find what you're looking for.

Preventive care and wellness

This section describes the eligible health services and supplies available under your plan when you are well.

Important notes:

1. You will see references to the following recommendations and guidelines in this section:
   - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
   - United States Preventive Services Task Force
   - Health Resources and Services Administration
   - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

   These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to eligible health services for diagnostic testing.

3. Gender-specific preventive care benefits include eligible health services described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

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

Eligible health services include office visits to your physician, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk Human Papillomavirus (HPV) DNA testing for women 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered newborns, an initial hospital checkup.

Preventive care immunizations

Eligible health services include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears and routine chlamydia screening tests. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

Preventive screening and counseling services

Eligible health services include screening and counseling by your health professional for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.
• **Obesity and/or healthy diet counseling**

  Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:
  - Preventive counseling visits and/or risk factor reduction intervention
  - Nutritional counseling
  - 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**

  Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:
  - Preventive counseling visits
  - Risk factor reduction intervention
  - A structured assessment

• **Use of tobacco products**

  Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:
  - Preventive counseling visits
  - Treatment visits
  - Class visits;
  - Tobacco cessation prescription and over-the-counter drugs
    - Eligible health services include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

  Tobacco product means a substance containing tobacco or nicotine such as:
  - Cigarettes
  - Cigars
  - Smoking tobacco
  - Snuff
  - Smokeless tobacco
  - Candy-like products that contain tobacco

• **Sexually transmitted infection counseling**

  Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

• **Genetic risk counseling for breast and ovarian cancer**

  Eligible health services include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.
Routine cancer screenings
Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- 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
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network provider who is an OB, GYN or OB/GYN.

Prenatal care
Eligible health services include your routine prenatal physical exams as Preventive Care, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your physician's, PCP's, OB's, GYN's, or OB/GYN's office.

Important note:
You should review the benefit under Eligible health services under your plan- Maternity and related newborn care and the exclusions sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services
Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support provider.

Breast feeding durable medical equipment
Eligible health services include renting or buying durable medical equipment you need to pump and store breast milk as follows:
Breast pump
Eligible health services include:

- Renting a hospital grade electric pump while your newborn child is confined in a hospital.
- The buying of:
  - An electric breast pump (non-hospital grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories
Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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

Family planning services – female contraceptives
Eligible health services include family planning services such as:

Counseling services
Eligible health services include counseling services provided by a physician, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices
Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a physician during an office visit.

Voluntary sterilization
Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

Important note:
See the following sections for more information:
- Family planning services - other
- Maternity and related newborn care
- Outpatient prescription drugs
- Treatment of basic infertility
Physicians and other health professionals

Physician services

Eligible health services include services by your physician to treat an illness or injury. You can get those services:

- At the physician’s office
- In your home
- In a hospital
- From any other inpatient or outpatient facility

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your surgery
- Your surgeon who you visit before and after the surgery
- Another surgeon who you go to for a second opinion before the surgery

Important note:

Some surgeries can be done safely in a physician’s office. For those surgeries, your plan will pay only for physician services and not for a separate fee for facilities.

Alternatives to physician office visits

Walk-in clinic

Eligible health services include health care services provided in walk-in clinics for:

- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic’s license
Hospital and other facility care

Hospital care

Eligible health services include inpatient and outpatient hospital care.

The types of hospital care services that are eligible for coverage include:

- Room and board charges up to the hospital’s semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of physicians employed by the hospital.
- Operating and recovery rooms.
- Intensive or special care units of a hospital.
- Administration of blood and blood derivatives, but not the expense of the blood or blood product.
- Radiation therapy.
- Cognitive rehabilitation.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.
- Services and supplies provided by the outpatient department of a hospital.

Alternatives to hospital stays

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient surgery performed in a surgery center or a hospital’s outpatient department.

Important note:
Some surgeries can be done safely in a physician’s office. For those surgeries, your plan will pay only for physician or PCP services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care provided by a home health care agency in the home, but only when all of the following criteria are met:

- You are homebound.
- Your physician orders them.
- The services take the place of your needing to stay in a hospital or a skilled nursing facility, or needing to receive the same services outside your home.
- The services are a part of a home health care plan.
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a physician or social worker.
Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the Short-term rehabilitation services and Habilitation therapy services sections and the schedule of benefits.

Home health care services do not include custodial care.

**Hospice care**

Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program.

The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Bereavement counseling
- Respite care

Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:

- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling
  - Dietary counseling

**Outpatient private duty nursing**

Eligible health services include private duty nursing care provided by an R.N. or L.P.N. for non-hospitalized acute illness or injury if your condition requires skilled nursing care and visiting nursing care is not adequate.

**Skilled nursing facility**

Eligible health services include inpatient skilled nursing facility care.

The types of skilled nursing facility care services that are eligible for coverage include:

- **Room and board**, up to the semi-private room rate
- Services and supplies that are provided during your stay in a skilled nursing facility

**Emergency services and urgent care**

Eligible health services include services and supplies for the treatment of an emergency medical condition or an urgent condition.

As always, you can get emergency care from network providers. However, you can also get emergency care from out-of-network providers.

Your coverage for emergency services and urgent care from out-of-network providers ends when Aetna and the attending physician determine that you are medically able to travel or to be transported to a network provider if you need more care.
As it applies to in-network coverage, you are covered for follow-up care only when your physician or PCP provides or coordinates it. If you use an out-of-network provider to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency
When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician or PCP but only if a delay will not harm your health.

Non-emergency condition
If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits and the exclusion- Emergency services and urgent care sections for specific plan details.

Medical care and treatment outside of the United States is excluded, with the exception of emergency medical care and/or treatment provided after the sudden onset of a medical condition which is deemed severe enough that lack of immediate medical attention could reasonably result in placing the patient’s health in serious jeopardy.

In case of an urgent condition
Urgent condition
If you need care for an urgent condition, you should first seek care through your physician or PCP. If your physician or PCP is not reasonably available to provide services, you may access urgent care from an urgent care facility.
Specific conditions

Autism spectrum disorder
Autism spectrum disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.

We will cover certain early intensive behavioral interventions such as applied behavior analysis. Applied behavior analysis is an educational service that is the process of applying interventions:

- That systematically change behavior, and
- That is responsible for observable improvements in behavior.

**Important note:**
Applied behavior analysis requires precertification by Aetna. The network provider is responsible for obtaining precertification. You are responsible for obtaining precertification if you are using an out-of-network provider.

Birthing center
Eligible health services include prenatal and postpartum care and obstetrical services from your provider. After your child is born, eligible health services include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care.

Diabetic equipment, supplies and education
Eligible health services include:

- Services and supplies
  - Foot care to minimize the risk of infection
  - Alcohol swabs
  - Glucagon emergency kits
- Equipment
  - External insulin pumps
  - Blood glucose monitors without special features, unless required due to blindness
- Training
  - Self-management training provided by a health care provider certified in diabetes self-management training

This coverage is for the treatment of insulin (type I) and non-insulin dependent (type II) diabetes and the treatment of elevated blood glucose levels during pregnancy.
Family planning services – other
Eligible health services include certain family planning services provided by your physician such as:
- Voluntary sterilization for males
- Abortion

Maternity and related newborn care
Eligible health services include prenatal and postpartum care and obstetrical services. After your child is born, eligible health services include:
- 48 hours of inpatient care in a hospital after a vaginal delivery
- 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a provider.

Substance related disorders treatment
Eligible health services include the treatment of substance abuse provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:
- Inpatient room and board at the semi-private room rate, and other services and supplies that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Treatment of substance abuse in a general medical hospital is only covered if you are admitted to the hospital’s separate substance abuse section or unit, unless you are admitted for the treatment of medical complications of substance abuse.

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

- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, advanced practice registered nurse, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group and family therapies for the treatment of substance abuse
  - Other outpatient substance abuse treatment such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance abuse provided under the direction of a physician
    - Intensive outpatient program provided in a facility or program for treatment of substance abuse provided under the direction of a physician
    - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications
    - Treatment of withdrawal symptoms
    - 23 hour observation
    - Peer counseling support by a peer support specialist
      - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.
Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dentist and hospital:

- Non-surgical treatment of infections or diseases.
- Surgery needed to:
  - Treat a fracture, dislocation, or wound.
  - Cut out cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.
- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after an injury.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes surgery on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your surgery is to implant or attach a covered prosthetic device.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the surgery is to improve function.
- Your surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.

Transplant services

Eligible health services include transplant services provided by a physician and hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T-Cell receptor therapy for FDA approved treatments

Network of transplant facilities

The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- A Non-IOE facility
Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

The National Medical Excellence Program® will coordinate all solid organ, bone marrow and CAR-T and T-Cell therapy services and other specialized care you need.

**Important note:**
If there is no **IOE facility** for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an **IOE facility** in another one of our networks. If you don’t get your transplant services at the **IOE facility** we designate, your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

**Treatment of infertility**

**Basic infertility**
Eligible health services include seeing a **network provider**:
- To diagnose and evaluate the underlying medical cause of **infertility**.
- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis surgery or, for men, varicocele surgery.

**Comprehensive infertility services**
Eligible health services include comprehensive **infertility** care. The first step to using your comprehensive infertility health care services is enrolling with our National Infertility Unit (NIU). To enroll you can reach our dedicated NIU at 1-800-575-5999.

**Infertility services**
You are eligible for **infertility** services if:
- You are covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse, referred to as “your partner”.
- There exists a condition that:
  - Is demonstrated to cause the disease of **infertility**.
  - Has been recognized by your **physician** or **infertility specialist** and documented in your or your partner’s medical records.
- You or your partner has not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have **infertility** that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have met the requirement for the number of months trying to conceive through egg and sperm contact.
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:
<table>
<thead>
<tr>
<th>You are</th>
<th>Number of months of unprotected timed sexual intercourse:</th>
<th>Number of donor artificial insemination cycles: Self paid/not paid for by plan</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
<th>The results of your unmedicated day 3 FSH test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A female under 35 years of age with a male partner</td>
<td>A. 12 months or more</td>
<td>B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test</td>
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<td></td>
<td>OR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A female under 35 years of age without a male partner</td>
<td>Does not apply</td>
<td>At least 12 cycles of donor insemination</td>
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<tr>
<td>A female 35 years of age or older with a male partner</td>
<td>A. 6 months or more</td>
<td>B. At least 6 cycles of donor insemination</td>
<td>6 months</td>
<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test</td>
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<td></td>
<td>OR</td>
<td></td>
<td></td>
<td>If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40</td>
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<td>A male of any age with a female partner under 35 years of age</td>
<td>12 months or more</td>
<td>Does not apply</td>
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</tr>
<tr>
<td>A male of any age with a female partner 35 years of age or older</td>
<td>6 months or more</td>
<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>
Our NIU is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:

- Enroll in the infertility program.
- Assist you with precertification of eligible health services.
- Coordinate precertification for comprehensive infertility when these services are eligible health services.
- Evaluate your medical records to determine whether comprehensive infertility services are reasonably likely to result in success.
- Determine whether comprehensive infertility services are eligible health services.

Your provider will request approval from us in advance for your infertility services. We will cover charges made by an infertility specialist for the following infertility services:

- Ovulation induction cycle(s) with menotropins.
- Intrauterine insemination.

A “cycle” is an attempt at ovulation induction or intrauterine insemination. The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

**Advanced reproductive technology**

Eligible health services include Assisted Reproductive Technology (ART). ART services are more advanced medical procedures or treatments performed to help a woman achieve pregnancy.

**ART services**

ART services include:

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers (Frozen Embryo Transfers (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery

You are eligible for ART services if:

- You are covered under this plan as an employee or as a covered dependent who is the employee’s legal spouse, referred to as “your partner”. Dependent children are covered under this plan for ART services only in the case of fertility preservation due to planned treatment for medical conditions that will result in infertility.
- There exists a condition that:
  - Is demonstrated to cause the disease of infertility.
  - Has been recognized by your physician or infertility specialist and documented in your or your partner’s medical records.
- You or your partner has not had a voluntary sterilization, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- You or your partner does not have infertility that is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause).
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this plan.
- You have exhausted the comprehensive infertility services benefits or have a clinical need to move on to ART procedures. You have met the requirement for the number of months trying to conceive through
egg and sperm contact.

- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level meets the following criteria:

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<td>A. 12 months or more or B. At least 12 cycles of donor insemination</td>
<td>12 months</td>
<td>Must be less than 19 mIU/mL in your most recent lab test to use your own eggs. If greater than 19 mIU/mL, you can use donor eggs or embryos but not your own eggs.</td>
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---|---|---|
A male of any age with a female partner under 35 years of age | 12 months or more | Does not apply | Does not apply | Does not apply |
A male of any age with a female partner 35 years of age or older | 6 months or more | Does not apply | Does not apply | Does not apply |

- If you have been diagnosed with premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services through age 45 regardless of FSH level.

**Fertility preservation**

Only cancer patients are eligible for fertility preservation. Fertility preservation involves the retrieval of mature eggs and/or sperm or the creation of embryos that are frozen for future use. You are eligible for fertility preservation only when you:

- Are believed to be fertile
- Have planned services that will result in infertility such as:
  - Chemotherapy
  - Pelvic radiotherapy
  - Other gonadotoxic therapy
  - Ovarian or testicular removal

Along with the eligibility requirements above, you are eligible for fertility preservation benefits if, for example:

- You, your partner or dependent child are planning treatment that is demonstrated to result in infertility. Planned treatments include:
  - Bilateral orchietomy (removal of both testicles)
  - Bilateral oophorectomy (removal of both ovaries)
  - Hysterectomy (removal of the uterus)
  - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
The eggs that will be retrieved for use are reasonably likely to result in a successful pregnancy by meeting the criteria below:

<table>
<thead>
<tr>
<th>You are</th>
<th>You need to have an unmedicated day 3 FSH test done within the past:</th>
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<td>If you are less than age 40, must be less than 19 mIU/mL in your most recent lab test. If you are age 40 and older, must be less than 19 mIU/mL in all prior tests performed after age 40.</td>
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Eligible health services for fertility preservation will be paid on the same basis as other ART services benefits for individuals who are infertile.

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility who can help:
- Enroll in the infertility program.
- Evaluate your medical records to determine whether ART services and fertility preservation services are reasonably likely to result in success.
- Determine whether ART services and fertility preservation services are eligible health services.
- Case manage for the provision of ART services and fertility preservation services for an eligible covered person.

Your provider will request approval from us in advance for your ART services and fertility preservation services. We will cover charges made by an ART specialist for the following ART services:
- Any combination of the following ART services:
  - In vitro fertilization (IVF)*
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers (Frozen Embryo Transfer (FET))
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. The embryo transfer itself is not covered. (See the What your plan doesn't cover - some eligible health service exceptions section.)
- Charges associated with your care when you will receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with obtaining sperm from your partner when they are covered under this plan for ART services.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.

A “cycle” is an attempt at a particular type of infertility treatment (e.g., GIFT, ZIFT, cryopreserved embryo transfers). The cycle begins with the initiation of therapy and ends when the treatment is followed by confirmation of non-pregnancy (either a negative pregnancy test or a menstrual period). In the case of
the achievement of pregnancy, a cycle is considered completed at 6 weeks following a positive pregnancy test. Each treatment type is counted as a separate cycle.

*Note: In some plans with limits on the number of cycles of IVF covered, “one” cycle of IVF may be considered as one elective single embryo transfer (ESET) cycle followed consecutively by a frozen single embryo transfer cycle. This cycle definition applies only to individuals who meet the criteria for ESET, as determined by our NIU and for whom the initial ESET cycle did not result in a documented fetal heartbeat. Eligible health services for ESET will be paid on the same basis as any other ART services benefit.

Specific therapies and tests

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a provider, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in the office
- A home care provider in your home

Infusion therapy is the parenteral (e.g. intravenous) administration of prescribed medications or solutions.

Certain infused medications may be covered under the outpatient prescription drug coverage. You can access the list of specialty 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 your ID card to determine if coverage is under the outpatient prescription drug benefit or this booklet.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.
Outpatient radiation therapy

Eligible health services include the following radiology services provided by a health professional:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Specialty prescription drugs

Eligible health services include specialty prescription drugs when they are:

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

You can access the list of specialty prescription drugs by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the outpatient prescription drug benefit or this booklet.

Certain injected and infused medications may be covered under the outpatient prescription drug coverage. You can access the list of specialty 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 your ID card to determine if coverage is under the outpatient prescription drug benefit or this booklet.

When injectable or infused services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician’s office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part of your inpatient hospital stay if it is part of a treatment plan ordered by your physician.

A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a hospital, skilled nursing facility, or physician’s office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.
Short-term rehabilitation services
Short-term rehabilitation services help you restore or develop skills and functioning for daily living.

Eligible health services include short-term rehabilitation services your physician prescribes. The services have to be performed by:

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

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

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:
  - Significantly improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure, or
  - Relearn skills so you can significantly improve your ability to perform the activities of daily living.
- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one’s thoughts with spoken words.

- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

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

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

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

Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.
Outpatient physical, occupational, and speech therapy

Eligible health services include:

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

Other services

Acupuncture

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered health services include treatment of nausea as a result of:

- chemotherapy;
- pregnancy; and
- post-operative procedures.

Ambulance service

Eligible health services include transport by professional ground ambulance services:

- To the first hospital to provide emergency services.
- From one hospital to another hospital if the first hospital cannot provide the emergency services you need.
- From a hospital to your home or to another facility if an ambulance is the only safe way to transport you.
- From your home to a hospital if an ambulance is the only safe way to transport you. Transport is limited to 100 miles.

Your plan also covers transportation to a hospital by professional air or water ambulance when:

- Professional ground ambulance transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one hospital to another and
  - The first hospital cannot provide the emergency services you need, and
  - The two conditions above are met.
Clinical trial therapies (experimental or investigational)

Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an “approved clinical trial” only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

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

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

Clinical trials (routine patient costs)

Eligible health services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a “qualified individual” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for coverage if you need it for long-term use.

Coverage includes:

- One item of DME for the same or similar purpose.
- Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

Hearing aids and exams

Eligible health services include hearing care that includes hearing exams, prescribed hearing aids and hearing aid services as described below.

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired human hearing
- Parts, attachments, or accessories
Hearing aid services are:
- Audiometric hearing exam and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist
  - An audiologist who is legally qualified in audiology, or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements; and who performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam
- Any other related services necessary to access, select and adjust or fit a hearing aid

**Prosthetic devices**

**Eligible health services** include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Prosthetic device means:
- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

Coverage includes:
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device

**Spinal manipulation**

**Eligible health services** include spinal manipulation to correct a muscular or skeletal problem, but only if your provider establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

**Vision care**

**Routine vision exams**

**Eligible health services** include a routine vision exam provided by an ophthalmologist or optometrist. The exam will include refraction and glaucoma testing.
Outpatient prescription drugs

What you need to know about your outpatient prescription drug plan
Read this section carefully so that you know:

- How to access network pharmacies
- Eligible health services under your plan
- What outpatient prescription drugs are covered
- Other services
- How you get an emergency prescription filled
- Where your schedule of benefits fits in
- What precertification requirements apply
- How do I request a medical exception
- What your plan doesn’t cover – some eligible health service exclusions
- How you share the cost of your outpatient prescription drugs

Some prescription drugs may not be covered or coverage may be limited. This does not keep you from getting prescription drugs that are not covered benefits. You can still fill your prescription, but you have to pay for it yourself. For more information see the Where your schedule of benefits fits in section, and see the schedule of benefits.

How to access network pharmacies

How do you find a network pharmacy?
You can find a network pharmacy in two ways:

- **Online:** By logging onto your Aetna Navigator® secure member website at www.aetna.com.
- **By phone:** Call the toll-free Member Services number on your member ID card. During regular business hours, a Member Services representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

You may go to any of the network pharmacies. Pharmacies include network retail, mail order and specialty pharmacies.

What if the pharmacy you have been using leaves the network?
Sometimes a pharmacy might leave the network. If this happens, you will have to get your prescriptions filled at another network pharmacy. You can use your provider directory or call the toll-free Member Services number on your member ID card to find another network pharmacy in your area.
Eligible health services under your plan

What does your outpatient prescription drug plan cover?
Any pharmacy service that meets these three requirements:
- They are listed in the Eligible health services under your plan section
- They are not carved out in the What your plan doesn’t cover - some eligible health service exceptions section
- They are not beyond any limits in the schedule of benefits

Your plan benefits are covered when you follow the plan’s general rules:
- You need a prescription from your prescriber.
- Your drug needs to be medically necessary for your illness or injury. See the Medical necessity and precertification requirements section.
- You need to show your ID card to the pharmacy when you get a prescription filled.

Your outpatient prescription drug plan includes drugs listed in the drug guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception is approved by us prior to the drug being picked up at the pharmacy. If it is medically necessary for you to use a prescription drug on the formulary exclusions list, you or your prescriber must request a medical exception. See the How to get a medical exception section.

Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. Your out-of-pocket costs may be less if you use a generic prescription drug when available.

Prescription drugs covered by this plan are subject to misuse, waste, and/or abuse utilization review by us, your provider, and/or your network pharmacy. The outcome of this review may include: limiting coverage of the applicable drug(s) to one prescribing provider and/or one network pharmacy, limiting the quantity, dosage, day supply, requiring a partial fill or denial of coverage.

What outpatient prescription drugs are covered
Your prescriber may give you a prescription in different ways, including:
- Writing out a prescription that you then take to a network pharmacy
- Calling or e-mailing a network pharmacy to order the medication
- Submitting your prescription electronically

Once you receive a prescription from your prescriber, you may fill the prescription at a network, retail, mail order or specialty pharmacy.

Retail pharmacy
Generally, retail pharmacies may be used for up to a 31 day supply of prescription drugs. You should show your ID card to the network pharmacy every time you get a prescription filled. The network pharmacy will submit your claim. You will pay any cost sharing directly to the network pharmacy.

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

All prescriptions and refills over a 31 day supply must be filled at a network mail order pharmacy.

Mail order pharmacy
Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition.
All 

prescription 

refills after the first refill at a 

network retail pharmacy 

must be filled at a 

network mail order pharmacy 

or a CVS pharmacy. 
The 

negotiated charge 

will be the same for 

prescriptions 

obtained at a CVS pharmacy 

or at a 

network mail order pharmacy.

After you obtain your first refill at a 

network retail pharmacy, 

you must notify us of whether you want to use 
your 

network mail order pharmacy 

benefit or a CVS pharmacy or continue to fill your 
prescriptions 

at a 

network retail pharmacy 

by calling the number on your member ID card. 
If you fail to inform us of your choice, 
then the next 
prescription 

refill (and any subsequent refills) at a 

network retail pharmacy 

will not be 

covered. 

You may contact us at any time to let us know that you intend to use a 

network retail pharmacy 

for future 
prescription 

refills.

Specialty pharmacy

Specialty prescription drugs 

often include typically high-cost drugs that require special handling, special storage 
or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. 
Each 
prescription 

is limited to a maximum 30 day supply. 
You can access the list of specialty prescription drugs 

by logging onto your Aetna Navigator® secure member website at 

www.aetna.com 

or calling the number on your ID card.

Specialty prescription drugs 

are covered when dispensed through a network 

specialty pharmacy 

or network retail pharmacy.

All specialty prescription drugs 

fills after the initial fill must be filled at a 

network specialty pharmacy 

except for 

urgent situations.

Other services

Preventive Contraceptives

For females who are able to reproduce, your outpatient 

prescription drug 

plan covers certain drugs and 
devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when 
prescribed by a 

prescriber 

and the 

prescription 

is submitted to the pharmacist for processing. Your 

outpatient prescription drug 

plan also covers related services and supplies needed to administer covered devices. 
At least one form of contraception in each of the methods identified by the FDA is included. 
You can access the list of contraceptive drugs by logging onto your Aetna Navigator® secure member website 
at 

www.aetna.com 

or calling the number on your ID card.

We cover over-the-counter (OTC) and 

generic prescription drugs 

and devices for each of the methods identified 

by the FDA at no cost share. 

If a 

generic prescription drug 

or device is not available for a certain method, you 

may obtain certain 

brand-name prescription drug 

for that method at no cost share.

Important note: 

You may qualify for a medical exception if your 

provider 

determines that the 

contraceptives covered standardly as preventive are not medically appropriate. 
Your 

prescriber 

may request a medical exception and submit the exception to us.
**Diabetic supplies**

**Eligible health services** include but are not limited to the following diabetic supplies upon **prescription** by a **prescriber**:

- Injection devices including insulin syringes, needles and pens
- Test strips - blood glucose, ketone and urine
- Blood glucose calibration liquid
- Lancet devices and kits
- Alcohol swabs
- Blood glucose meters and insulin pumps

Also see your medical plan benefits for coverage of blood glucose meters and insulin pumps.

**Immunizations**

**Eligible health services** include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You should call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.

**Infertility drugs**

**Eligible health services** include oral and injectable synthetic ovulation stimulant **prescription drugs** used primarily for the purpose of treating the underlying cause of **infertility**.

**Off-label use**

U.S. Food and Drug Administration (FDA)-approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for your condition(s). Eligibility for coverage is subject to the following:

- The drug must be accepted as safe and effective to treat your condition(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.)
  - The National Comprehensive Cancer Network (NCCN) Drug and Biologics Compendium; or
- Use for your condition(s) has been proven as safe and effective by at least one well-designed controlled clinical trial, (i.e., a Phase III or single center controlled trial, also known as Phase II). 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 condition(s) is equal to the dosage for the same condition(s) as suggested in the FDA-approved labeling or by one of the standard compendia noted above.
  - The dosage has been proven to be safe and effective for your condition(s) by one or more well-designed controlled clinical trials. Such a trial must be published in a peer reviewed medical journal.

Health care services related to off-label use of these drugs may be subject to **precertification** or other requirements or limitations.

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

**Eligible health services** include any drug prescribed for the treatment of cancer if it 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.
Preventive care drugs and supplements
Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the ACA guidelines when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

Risk reducing breast cancer prescription drugs
Eligible health services include prescription drugs used to treat people who are at:
- Increased risk for breast cancer, and
- Low risk for adverse medication side effects

Sexual dysfunction/enhancement
Eligible health services include prescription drugs for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call the toll-free number on your ID card.

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

How you get an emergency prescription filled
You may not have access to a network pharmacy in an emergency or urgent care situation, or you may be traveling outside of the plan’s service area. If you must fill a prescription in either situation, we will reimburse you as shown in the table below.

<table>
<thead>
<tr>
<th>Type of pharmacy</th>
<th>Your cost share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network pharmacy</td>
<td>• You pay the copayment.</td>
</tr>
<tr>
<td>Out-of-network pharmacy</td>
<td>• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts.</td>
</tr>
<tr>
<td></td>
<td>• Coverage is limited to items obtained in connection with covered emergency and out-of-area urgent care services.</td>
</tr>
<tr>
<td></td>
<td>• Submission of a claim doesn’t guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment/payment percentage.</td>
</tr>
</tbody>
</table>

Where your schedule of benefits fits in
You are responsible for paying your part of the cost sharing. The schedule of benefits shows any benefit limitations and any out-of-pocket costs you are responsible for. Keep in mind that you are responsible for costs not covered under this plan.

Your prescription drug costs are based on:
- The type of prescription drug you’re prescribed.
- Where you fill your prescription.

The plan may, in certain circumstances, make some brand-name prescription drugs available to you at the generic prescription drug copayment level.
How your copayment/payment percentage works
Your copayment/payment percentage is the amount you pay for each prescription fill or refill. Your schedule of benefits shows you which copayments/payment percentage you need to pay for specific prescription fill or refill. You will pay any cost sharing directly to the network pharmacy.

What precertification requirements apply
For certain drugs, you, your prescriber or your pharmacist needs to get approval from us before we will cover the drug. This is called "precertification". The requirement for getting approval in advance guides appropriate use of precertified drugs and makes sure they are medically necessary. For the most up-to-date information, call the toll-free number on your member ID card or log on to your Aetna Navigator® secure member website at www.aetna.com.

How do I request a medical exception?
Sometimes you or your prescriber may seek a medical exception to get health care services for drugs not listed on the drug guide or for which health care services are denied through precertification. You, someone who represents you or your prescriber can contact us and will need to provide us with the required clinical documentation. Any exception granted is based upon an individual, case by case decision, and will not apply to other members. If approved by us, you will receive the preferred drug or non-preferred drug benefit level.

You, someone who represents you or your prescriber may seek a quicker medical exception process to get coverage for non-covered drugs in an urgent situation. An urgent situation happens when you have a health condition that may seriously affect your life, health, or ability to get back maximum function or when you are going through a current course of treatment using a non-preferred drug. You, someone who represents you or your prescriber may submit a request for a quicker review for an urgent situation by:

- Contacting our Precertification Department at 1-855-582-2025
- Faxing the request to 1-855-330-1716
- 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 we receive your request and will tell you, someone who represents you and your prescriber of our decision.

Prescribing units
Some outpatient prescription drugs are subject to quantity limits. These quantity limits help your prescriber and pharmacist check that your outpatient prescription drug is used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these quantity limits.

Any outpatient 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.
Exclusions: What your plan doesn’t cover

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the Eligible health services under your plan section. And we told you there, that some of those health care services and supplies have exclusions. For example, physician care is an eligible health service but physician care for cosmetic surgery is never covered. This is an exclusion.

In this section we tell you about the exclusions. We've grouped them to make it easier for you to find what you want.

• Under "General exclusions" we’ve explained what general services and supplies are not covered under the entire plan.
• Below the general exclusions, in “Exclusions under specific types of care,” we’ve explained what services and supplies are exceptions under specific types of care or conditions.

Please look under both categories to make sure you understand what exclusions may apply in your situation.

And just a reminder, you'll find coverage limitations in the schedule of benefits.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
• The provision of blood to the hospital, other than blood derived clotting factors.
• Any related services including processing, storage or replacement expenses.
• The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

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. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

Counseling
• Marriage, religious, family, career, social adjustment, pastoral, or financial counseling.

Court-ordered services and supplies
• Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

Custodial care
Examples are:
• Routine patient care such as changing dressings, periodic turning and positioning in bed
• Administering oral medications
• Care of a stable tracheostomy (including intermittent suctioning)
• Care of a stable colostomy/ileostomy
• Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
• Care of a bladder catheter (including emptying/changing containers and clamping tubing)
• Watching or protecting you
• Respite care, adult (or child) day care, or convalescent care
• Institutional care. This includes room and board for rest cures, adult day care and convalescent care
• Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
• Any other services that a person without medical or paramedical training could be trained to perform
• Any service that can be performed by a person without any medical or paramedical training

Dental care except as covered in the Eligible health services under your plan Oral and maxillofacial treatment section.
Dental services related to:
• The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
• Dental services related to the gums
• Apicoectomy (dental root resection)
• Orthodontics
• Root canal treatment
• Soft tissue impactions
• Bony impacted teeth
• Alveolectomy
• Augmentation and vestibuloplasty treatment of periodontal disease
• False teeth
• Prosthetic restoration of dental implants
• Dental implants

This exclusion does not include bone fractures, removal of tumors, and odontogenic cysts

Early intensive behavioral interventions
Examples of those services are:
• Early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

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

Examinations
Any health examinations needed:
• Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
• Because a law requires it.
• To buy insurance or to get or keep a license.
• To travel.
• To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational
• Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the Eligible health services under your plan – Other services section.

Facility charges
For care, services or supplies provided in:
• Rest homes
• Assisted living facilities
• Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
• Health resorts
• Spas or sanitariums
• Infirmaries at schools, colleges, or camps

Foot care
• Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, or fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Growth/height care
• A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
• Surgical procedures, devices and growth hormones to stimulate growth

Jaw joint disorder
• Non-surgical treatment of jaw joint disorder (TMJ)
• Jaw joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

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

Medical supplies – outpatient disposable
• Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
- Support hose
- Bandages
- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Other primary payer
- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient prescription or non-prescription drugs and medicines
- Outpatient prescription or non-prescription drugs and medicines provided by the employer or through a third party vendor contract with the employer.

Personal care, comfort or convenience items
- Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy charges
- Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the Eligible health services under your plan section

Routine exams
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan section

Services provided by a family member
- Services provided by a spouse, parent, child, stepchild, brother, sister, in-law or any household member

Services, supplies and drugs received outside of the United States
- Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

Telemedicine
- Services given by providers that are not contracted with Aetna as telemedicine providers
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls for behavioral health services
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation
- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the Eligible health services under your plan – Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity
- 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

Wilderness treatment programs
- Wilderness treatment programs (whether or not the program is part of a 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 illness or injuries

- Coverage available to you under worker’s compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.

Additional exclusions for specific types of care

Preventive care and wellness

- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician’s direction
- Psychiatric, psychological, personality or emotional testing or exams

Family planning services

- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement.

Physicians and other health professionals

There are no additional exclusions specific to physicians and other health professionals.

Hospital and other facility care

Alternatives to facility stays

Outpatient surgery and physician surgical services

- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section.)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

Home health care

- Services for infusion therapy
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
Hospice care
- 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 and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Outpatient private duty nursing
(See home health care in the Eligible health services under your plan and Outpatient and inpatient skilled nursing care sections regarding coverage of nursing services).

Specific conditions

Behavioral health treatment
Services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):
- **Stay** in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Family planning services - other
- Reversal of voluntary sterilization procedures including related follow-up care
- Family planning services received while confined as an inpatient in a **hospital** or other facility

Maternity and related newborn care
- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Mental health /substance use disorders conditions
The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:
- Paraphilia’s
- Tobacco use disorders and nicotine dependence, except as described in the Coverage and exclusions – Preventive care section
- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor function
- Specific developmental disorders of speech and language
- Other disorders of psychological development
**Obesity (bariatric) surgery**
- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity** except as described in the Eligible health services under your plan – Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - **Surgical procedures**, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

**Oral and maxillofacial treatment (mouth, jaws and teeth)**
- Dental implants

**Transplant services**
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

**Treatment of infertility**
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation (freezing) of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm from a person not covered under this plan for ART services.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
Specific therapies and tests

Outpatient infusion therapy
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs
- Specialty prescription drugs and medicines provided by your employer or through a third party vendor contract with your employer.
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan.

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

Other services

Ambulance services
- Fixed wing air ambulance from an out-of-network provider

Clinical trial therapies (experimental or investigational)
- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the Eligible health services under your plan - Clinical trial therapies (experimental or investigational) section.

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).
Durable medical equipment (DME)
Examples of these items are:
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Hearing aids and exams
The following services or supplies:
- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

Nutritional supplements
- Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Other services section.

Prosthetic devices
- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Vision Care
Adult vision care
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes
Vision care services and supplies
Your plan does not cover vision care services and supplies, except as described in the Eligible health services under your plan – Other services section.

- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

Outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Cosmetic drugs

- Medications or preparations used for cosmetic purposes.

Compounded prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)

- Including compounded bioidentical hormones

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications

- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
- That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilars (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Pharmacy and Therapeutics Committee
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task
Force (USPSTF)

- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are 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 or other medications.
- That are 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)**

**Genetic care**
- Any treatment, device, drug, service 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**

**Immunization or immunological agents** except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section.

**Implantable drugs and associated devices** except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section.

**Injectables:**
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

**Prescription drugs:**
- Dispensed by other than a network retail, mail order and specialty pharmacies except as specifically provided in the What prescription drugs are covered section.
- Dispensed by a mail order pharmacy that is an out-of-network pharmacy, except in a medical emergency or urgent care situation except as specifically provided in the How to get an emergency prescription filled section.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- 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.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- 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 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.

**Refills**

- Refills dispensed more than one year from the date the latest **prescription order** was written.

**Replacement of lost or stolen prescriptions**

**Smoking cessation**

- Smoking cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

**Test agents except diabetic test agents**

**We reserve the right to exclude:**

- A manufacturer’s product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**.

- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**.
Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are eligible health services, the foundation for getting covered care is the network. This section tells you about network and out-of-network providers.

Network providers
We have contracted with providers to provide eligible health services to you. These providers make up the network for your plan. For you to receive the network level of benefits you must use network providers for eligible health services. There are some exceptions:

- Emergency services – refer to the description of emergency services and urgent care in the Eligible health services under your plan section
- Urgent care – refer to the description of emergency services and urgent care in the Eligible health services under your plan section

You may select a network provider from the directory through your Aetna Navigator® secure member website at www.aetna.com. You can search our online directory, DocFind®, for names and locations of providers.

You will not have to submit claims for treatment received from network providers. Your network provider will take care of that for you. And we will directly pay the network provider for what the plan owes.

Your PCP
We encourage you to access eligible health services through a PCP. They will provide you with primary care.

A PCP can be any of the following providers available under your plan:
- General practitioner
- Family physician
- Internist
- Pediatrician

How do you choose your PCP?
You can choose a PCP from the list of PCPs in our directory. See the Who provides the care, Network providers section.

Each covered family member is encouraged to select their own PCP. You may each select your own PCP. You should select a PCP for your covered dependent if they are a minor or cannot choose a PCP on their own.

What will your PCP do for you?
Your PCP will coordinate your medical care or may provide treatment. They may send you to other network providers.

Your PCP can also:
- Order lab tests and radiological services.
-Prescribe medicine or therapy.
- Arrange a hospital stay or a stay in another facility.

How do I change my PCP?
You may change your PCP at any time. You can call us at the toll-free number on your ID card or log on to your Aetna Navigator® secure member website at www.aetna.com to make a change.
Out-of-network providers
You also have access to out-of-network providers. This means you can receive eligible health services from an out-of-network provider. If you use an out-of-network provider to receive eligible health services, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your out-of-network deductible
- Your out-of-network payment percentage
- Any charges over our recognized charge
- Submitting your own claims and getting precertification

Keeping a provider you go to now (continuity of care)
You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network.
- You are already a member of Aetna and your provider stops being in our network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

<table>
<thead>
<tr>
<th>If you are a new enrollee and your provider is an out-of-network provider</th>
<th>When your provider stops participation with Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for approval</td>
<td>You need to complete a Transition Coverage Request form and send it to us. You can get this form by calling the toll-free number on your ID card. You or your provider should call Aetna for approval to continue any care.</td>
</tr>
<tr>
<td>Length of transitional period</td>
<td>Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. Care will continue during a transitional period, usually 90 days, but this may vary based on your condition. This date is based on the date the provider terminated their participation with Aetna.</td>
</tr>
</tbody>
</table>

If you are pregnant and have entered your second trimester, the transitional period will include the time required for postpartum care directly related to the delivery.

We will authorize coverage for the transitional period only if the provider agrees to our usual terms and conditions for contracting providers.

What the plan pays and what you pay
Who pays for your eligible health services – this plan, both of us, or just you? That depends. This section gives the general rule and explains these key terms:

- Your deductible
- Your copayments/payment percentage
- Your maximum out-of-pocket limit

We also remind you that sometimes you will be responsible for paying the entire bill: for example, if you get care that is not an eligible health service.
The general rule
When you get eligible health services:

- You pay for the entire expense up to any deductible limit.

And then

- The plan and you share the expense up to any maximum out-of-pocket limit. The schedule of benefits lists how much your plan pays and how much you pay for each type of health care service. Your share is called a copayment/payment percentage.

And then

- The plan pays the entire expense after you reach your maximum out-of-pocket limit.

When we say “expense” in this general rule, we mean the negotiated charge for a network provider, and the recognized charge for an out-of-network provider. See the Glossary section for what these terms mean.

Important exception – when your plan pays all
Under the in-network level of coverage, your plan pays the entire expense for all eligible health services under the preventive care and wellness benefit.

Important exceptions – when you pay all
You pay the entire expense for an eligible health service:

- When you get a health care service or supply that is not medically necessary. See the Medical necessity and precertification requirements section.
- When your plan requires precertification, your physician requested it, we refused it, and you get an eligible health service without precertification. See the Medical necessity and precertification requirements section.

In all these cases, the provider may require you to pay the entire charge. Any amount you pay will not count towards your deductible or towards your maximum out-of-pocket limit.

Special financial responsibility
You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage
- Charges, expenses, or costs in excess of the negotiated charge

Where your schedule of benefits fits in

How your deductible works
Your deductible is the amount you need to pay, after paying your copayment or payment percentage, for eligible health services per Calendar Year as listed in the schedule of benefits. Your copayment or payment percentage does not count toward your deductible.
How your copayment/payment percentage works
Your copayment/payment percentage is the amount you pay for eligible health services. Your schedule of benefits shows you which copayments/payment percentage you need to pay for specific eligible health services.

You will pay the physician, PCP copayment/payment percentage when you receive eligible health services from any PCP.

How your maximum out-of-pocket limit works
You will pay your deductible and copayments or payment percentage up to the maximum out-of-pocket limit for your plan. Your schedule of benefits shows the maximum out-of-pocket limits that apply to your plan. Once you reach your maximum out-of-pocket limit, your plan will pay for covered benefits for the remainder of that Calendar Year.

Important note:
See the schedule of benefits for any deductibles, copayments/payment percentage, maximum out-of-pocket limit and maximum age, visits, days, hours, admissions that may apply.
Claim decisions and appeals procedures

In the previous section, we explained how you and the plan share responsibility for paying for your eligible health services.

When a claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think we got it wrong.

Claims are processed in the order in which they are received.

Claim procedures
For claims involving out-of-network providers:

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit a claim</td>
<td>• You should notify and request a claim form from your employer.</td>
<td>• Within 15 working days of your request.</td>
</tr>
<tr>
<td></td>
<td>• The claim form will provide instructions on how to complete and where to send the form(s).</td>
<td>• If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.</td>
</tr>
<tr>
<td>Proof of loss (claim)</td>
<td>• A completed claim form and any additional information required by your employer.</td>
<td>• No later than 90 days after you have incurred expenses for covered benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• We won’t void or reduce your claim if you can’t send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify us.</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>• Written proof must be provided for all benefits.</td>
<td>• Benefits will be paid as soon as the necessary proof to support the claim is received.</td>
</tr>
<tr>
<td></td>
<td>• If any portion of a claim is contested by us, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.</td>
<td></td>
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</tbody>
</table>
Types of claims and communicating our claim decisions
You or your provider are required to send us a claim in writing. You can request a claim form from us. And we will review that claim for payment to the provider.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent care claim
An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim
A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them.

Post-service claim
A post service claim is a claim that involves health care services you have already received.

Concurrent care claim extension
A concurrent care claim extension occurs when you ask us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent care claim reduction or termination
A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

We may need to tell your physician about our decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial determination (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>24 hours for urgent request*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15 calendar days</td>
</tr>
<tr>
<td>Extensions</td>
<td>Non</td>
<td>15 days</td>
<td>15 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
<td>----------------</td>
</tr>
<tr>
<td>Additional information request (us)</td>
<td>72 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Response to additional information request (you)</td>
<td>48 hours</td>
<td>45 days</td>
<td>45 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*We have to receive the request at least 24 hours before the previously approved health care services end.

**Adverse benefit determinations**

We pay many claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes we pay only some of the claim. And sometimes we deny payment entirely. Any time we deny even part of the claim that is an “adverse benefit determination” or “adverse decision”. It is also an “adverse benefit determination” if we rescind your coverage entirely.

If we make an adverse benefit determination, we will tell you in writing.

**The difference between a complaint and an appeal**

**A Complaint**

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

**An Appeal**

You can ask us to re-review an adverse benefit determination. This is called an appeal. You can appeal to us verbally or in writing.

**Appeals of adverse benefit determinations**

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of adverse benefit determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name
- The employer’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form by contacting us. You can use an authorized representative at any level of appeal.

65
You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

**Urgent care or pre-service claim appeals**

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out a form.

We will provide you with any new or additional information that we used or that was developed by us to review your claim. We will provide this information at no cost to you before we give you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before we tell you what our final decision is.

**Timeframes for deciding appeals**

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

<table>
<thead>
<tr>
<th>Type of notice</th>
<th>Urgent care claim</th>
<th>Pre-service claim</th>
<th>Post-service claim</th>
<th>Concurrent care claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal determinations at each level (us)</td>
<td>36 hours</td>
<td>15 days</td>
<td>30 days</td>
<td>As appropriate to type of claim</td>
</tr>
<tr>
<td>Extensions</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Exhaustion of appeals process**

In most situations you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- We did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and us.

**External review**

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:

- Our claim decision involved medical judgment.
- We decided the service or supply is not **medically necessary** or not appropriate.
- We decided the service or supply is **experimental or investigational**.
- You have received an adverse determination.

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the
external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:
- To Aetna
- Within 123 calendar days (four months) of the date you received the decision from us
- And you must include a copy of the notice from us and all other important information that supports your request

Aetna will:
- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow our contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information.

We will stand by the decision that the ERO makes, unless we can show conflict of interest, bias or fraud.

When an appeal is not eligible for ERO or when the appeal is upheld at the ERO level, Aetna will inform the member of their right to appeal to the plan sponsor for voluntary level of review.

**How long will it take to get an ERO decision?**
We will tell you of the ERO decision not more than 45 calendar days after we receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call us or send us a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

**For initial adverse determinations**
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

**For final adverse determinations**
Your provider tells us that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.
**Recordkeeping**
We will keep the records of all complaints and appeals for at least 10 years.

**Fees and expenses**
We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.
Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms
Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:
- A health care expense that any of your health plans cover to any degree. If the health care service is not covered by any of the plans, it is not an allowable expense. For example, cosmetic surgery generally is not an allowable expense under this plan.

In this section when we talk about a “plan” through which you may have other coverage for health care expenses, we mean:
- Group or non-group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- An automobile insurance policy
- Medicare or other governmental benefits
- Any contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works
- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable expenses

Determining who pays
Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

<table>
<thead>
<tr>
<th>If you are covered as a:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-dependent or dependent</td>
<td>The plan covering you as an employee or retired employee.</td>
<td>The plan covering you as a dependent.</td>
</tr>
</tbody>
</table>
| Exception to the rule above when you are eligible for Medicare | If you or your spouse have Medicare coverage, the rule above may be reversed. If you have any questions about this you can contact us:  
  • Online: Log on to your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com). Select Find a Form, then select Your Other Health Plans.  
  • By phone: Call the toll-free number on your ID card. |
<table>
<thead>
<tr>
<th><strong>COB rules for dependent children</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child of:</strong></td>
</tr>
<tr>
<td>- Parents who are married or living together</td>
</tr>
<tr>
<td>The “birthday rule” applies. The plan of the parent whose birthday* (month and day only) falls earlier in the <strong>calendar year</strong>.</td>
</tr>
<tr>
<td>*Same birthdays--the plan that has covered a parent longer is primary</td>
</tr>
<tr>
<td>*<em>The plan of the parent born later in the year (month and day only)</em></td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
</tr>
<tr>
<td>- Parents separated or divorced or not living together</td>
</tr>
<tr>
<td>- With court-order</td>
</tr>
<tr>
<td>The plan of the parent whom the court said is responsible for health coverage</td>
</tr>
<tr>
<td>But if that parent has no coverage then their spouse’s plan is primary</td>
</tr>
<tr>
<td>The plan of the other parent But if that parent has no coverage, then their spouse’s plan is primary</td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
</tr>
<tr>
<td>- Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody</td>
</tr>
<tr>
<td>Primary and secondary coverage is based on the birthday rule</td>
</tr>
<tr>
<td><strong>Child of:</strong></td>
</tr>
<tr>
<td>- Parents separated or divorced or not living together and there is no court-order</td>
</tr>
<tr>
<td>The order of benefit payments is:</td>
</tr>
<tr>
<td>- The plan of the custodial parent pays first</td>
</tr>
<tr>
<td>- The plan of the spouse of the custodial parent (if any) pays second</td>
</tr>
<tr>
<td>- The plan of the noncustodial parents pays next</td>
</tr>
<tr>
<td>- The plan of the spouse of the noncustodial parent (if any) pays last</td>
</tr>
<tr>
<td><strong>Child covered by:</strong></td>
</tr>
<tr>
<td>Individual who is not a parent (i.e. stepparent or grandparent)</td>
</tr>
<tr>
<td>Treat the person the same as a parent when making the order of benefits determination:</td>
</tr>
<tr>
<td>See <strong>Child of content above</strong></td>
</tr>
<tr>
<td><strong>Active or inactive employee</strong></td>
</tr>
<tr>
<td>The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)</td>
</tr>
<tr>
<td>A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)</td>
</tr>
<tr>
<td><strong>COBRA or state continuation</strong></td>
</tr>
<tr>
<td>The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage</td>
</tr>
<tr>
<td>COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree</td>
</tr>
<tr>
<td><strong>Longer or shorter length of coverage</strong></td>
</tr>
<tr>
<td>If none of the above rules determine the order of payment, the plan that has covered the person longer is primary</td>
</tr>
</tbody>
</table>
Other rules do not apply

If none of the above rules apply, the plans share expenses equally

How are benefits paid?

<table>
<thead>
<tr>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The primary plan pays your claims as if there is no other health plan involved</td>
<td>The secondary plan calculates payment as if the primary plan did not exist and then applies that amount to any allowable expenses under the secondary plan that was not covered by the primary plan. The secondary plan will reduce payments so the total payments do not exceed 100% of the total allowable expense</td>
</tr>
</tbody>
</table>

How COB works with Medicare

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

Medicare, when used in this plan, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It also 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 when you are covered under it by reason of:

- Age, disability, or
- End stage renal disease

When you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, this plan is the primary plan, which means that the plan pays benefits before Medicare pays benefits. Sometimes, this plan is the secondary plan, and pays benefits after Medicare or after an amount that Medicare would have paid had you been covered.

Who pays first?

<table>
<thead>
<tr>
<th>If you are eligible due to age and have group health plan coverage based on your or your spouse’s current employment and:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>The employer has 20 or more employees</td>
<td>Your plan</td>
<td>Medicare</td>
</tr>
<tr>
<td>You are retired</td>
<td>Medicare</td>
<td>Your plan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have Medicare because of:</th>
<th>Primary plan</th>
<th>Secondary plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>End stage renal disease (ESRD)</td>
<td>Your plan will pay first for the first 30 months. Medicare will pay first after this 30 month period.</td>
<td>Medicare</td>
</tr>
</tbody>
</table>
A disability other than ESRD and the employer has more than 100 employees

<table>
<thead>
<tr>
<th>A disability other than ESRD and the employer has more than 100 employees</th>
<th>Your plan</th>
<th>Medicare</th>
</tr>
</thead>
</table>

Note regarding ESRD: If you were already eligible for Medicare due to age and then became eligible due to ESRD, Medicare will remain your primary plan and this plan will be secondary.

This plan is secondary to Medicare in all other circumstances.

How are benefits paid?

<table>
<thead>
<tr>
<th>We are primary</th>
<th>We pay your claims as if there is no Medicare coverage.</th>
</tr>
</thead>
</table>

| Medicare is primary | We calculate our benefit as if there were no Medicare coverage and reduce our benefit so that when combined with the Medicare payment, the total payment is no more than 100% of the allowable expense. |

Other health coverage updates – contact information
You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

- **Online:** Log on to your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com). Select Find a Form, then select Your Other Health Plans.
- **By phone:** Call the toll-free number on your ID card.

Right to receive and release needed information
We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other health plans.

Right to pay another carrier
Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery
If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid, or
- Any other plan that is responsible under these COB rules.
When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends. And when you may still be able to continue coverage.

When will your coverage end?
Your coverage under this plan will end on the earliest of:

- This plan is discontinued/ends.
- You voluntarily stop your coverage.
- The group contract ends.
- The last day of the month you are no longer eligible.
- The last day of the month your employment with the Company ends.
- The last day of the month you stop making the required contributions.
- The last day of the month Aetna receives written notice from University of Hartford to end your coverage, or the date requested in the notice, if not later; or
- The last day of the month you retire under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.
- You become covered under another medical plan offered by your employer.

When will coverage end for any dependents?
Coverage for your eligible dependent will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making required contributions.
- The last day of the month Aetna receives written notice from University of Hartford to end your coverage, or the date requested in the notice, if later; or
- The last day of the month your dependents no longer qualify as dependents under this Plan.

When coverage may continue under the plan
Your coverage under this plan will continue if:

Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by your employer and us. If required contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:

- Your coverage may continue, until stopped by your employer.

Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by your employer. If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:

- Your coverage will stop on the date that your employment ends.

Your employment ends because:
- Your job has been eliminated
- You have been placed on severance. You may be able to continue coverage. See the Special coverage options after your plan coverage ends section.

Your employment ends because of a paid or unpaid medical leave of absence If contributions are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:

- Your coverage may continue until
<table>
<thead>
<tr>
<th>Your employment ends because of a leave of absence that is not a medical leave of absence</th>
<th>stopped by the employer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>If contributions are made for you, you may be able to continue coverage under the plan as long as your employer agrees to do so and as described below:</td>
<td></td>
</tr>
<tr>
<td>• Your coverage may continue until stopped by your employer but not beyond 1 month from the start of the absence.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your employment ends because of a military leave of absence.</th>
<th>If contributions are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.</td>
<td></td>
</tr>
</tbody>
</table>

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

**What happens to your dependents if you die?**
Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

**Why would we end you and your dependents coverage?**
We will give you 31 days advance written notice if we end your coverage because:

- You do not cooperate or give facts that we need to administer the *COB* provisions.

We may immediately end your coverage if:

- You commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage.
  
  You can refer to the *Administrative information - Intentional deception* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayments for periods after the date your coverage ended.
When will we send you a notice of your coverage ending?
We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends. Here is how the date is determined (other than the circumstances described above in “Why we would end your coverage”).

Your coverage will end on the last day of the month of active employment.

Coverage will end for you and any dependents on the earlier of the date the group contract terminates or at the end of the period defined by your employer following the date on which you no longer meet the eligibility requirements.
Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Rights

What are your COBRA rights?
COBRA gives some people the right to keep their health coverage for 18, 29 or 36 months after a “qualifying event”. COBRA usually applies to employers of group sizes of 20 or more.

Here are the qualifying events that trigger COBRA continuation, which is eligible for continuation and how long coverage can be continued.

<table>
<thead>
<tr>
<th>Qualifying event causing loss of coverage</th>
<th>Covered persons eligible for continued coverage</th>
<th>Length of continued coverage (starts from the day you lose current coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your active employment ends for reasons other than gross misconduct</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td>Your working hours are reduced</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
<tr>
<td>You divorce or legally separate and are no longer responsible for dependent coverage</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to benefits under Medicare</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>Your covered dependent children no longer qualify as dependent under the plan</td>
<td>Your dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>You die</td>
<td>Your dependents</td>
<td>36 months</td>
</tr>
<tr>
<td>You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy</td>
<td>You and your dependents</td>
<td>18 months</td>
</tr>
</tbody>
</table>
When do I receive COBRA information?
The chart below lists who is responsible for giving the notice, the type of notice they are required to give and the timing.

<table>
<thead>
<tr>
<th>Notice</th>
<th>Requirement</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>General notice – employer or Aetna</td>
<td>Notify you and your dependents of COBRA rights.</td>
<td>Within 90 days after active employee coverage begins</td>
</tr>
<tr>
<td>Notice of qualifying event – employer</td>
<td>• Your active employment ends for reasons other than gross misconduct</td>
<td>Within 30 days of the qualifying event or the loss of coverage, whichever occurs later</td>
</tr>
<tr>
<td>Employee must notify employer within 30 days from date of qualifying event and then the employer notifies Aetna</td>
<td>• Your working hours are reduced</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You become entitled to benefits under Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You die</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy</td>
<td></td>
</tr>
<tr>
<td>Election notice – employer or Aetna</td>
<td>Notify you and your dependents of COBRA rights when there is a qualifying event</td>
<td>Within 14 days after notice of the qualifying event</td>
</tr>
<tr>
<td>Notice of unavailability of COBRA – employer or Aetna</td>
<td>Notify you and your dependents if you are not entitled to COBRA coverage.</td>
<td>Within 14 days after notice of the qualifying event</td>
</tr>
<tr>
<td>Termination notice – employer or Aetna</td>
<td>Notify you and your dependents when COBRA coverage ends before the end of the maximum coverage period</td>
<td>As soon as practical following the decision that continuation coverage will end</td>
</tr>
</tbody>
</table>
You/your dependents notification requirements

<table>
<thead>
<tr>
<th>Notice of qualifying event – qualified beneficiary</th>
<th>Notify the employer if:</th>
<th>Within 60 days of the qualifying event or the loss of coverage, whichever occurs later</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- You divorce or legally separate and are no longer responsible for dependent coverage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Your covered dependent children no longer qualify as a dependent under the plan</td>
<td></td>
</tr>
</tbody>
</table>

Disability notice

<table>
<thead>
<tr>
<th>Notify the employer if:</th>
<th>Within 60 days of the decision of disability by the Social Security Administration, and before the 18 month coverage period ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Social Security Administration determines that you or a covered dependent qualify for disability status</td>
<td></td>
</tr>
</tbody>
</table>

Notice of qualified beneficiary’s status change to non-disabled

<table>
<thead>
<tr>
<th>Notify the employer if:</th>
<th>Within 30 days of the Social Security Administration’s decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Social Security Administration decides that the beneficiary is no longer disabled</td>
<td></td>
</tr>
</tbody>
</table>

Enrollment in COBRA

<table>
<thead>
<tr>
<th>Notify the employer if:</th>
<th>60 days from the qualifying event. You will lose your right to elect, if you do not:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- You are electing COBRA</td>
<td>- Respond within the 60 days</td>
</tr>
<tr>
<td></td>
<td>- And send back your application</td>
</tr>
</tbody>
</table>

How can you extend the length of your COBRA coverage?
The chart below shows qualifying events after the start of COBRA (second qualifying events):

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Person affected (qualifying beneficiary)</th>
<th>Total length of continued coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled within the first 60 days of COBRA coverage (as determined by the Social Security Administration)</td>
<td>You and your dependents</td>
<td>29 months (18 months plus an additional 11 months)</td>
</tr>
</tbody>
</table>

- You die
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependent under the plan

| You and your dependents | Up to 36 months |
How do you enroll in COBRA?
You enroll by sending in an application and paying the premium. The employer has 30 days to send you a COBRA election notice. It will tell you how to enroll and how much it will cost. You can take 60 days from the qualifying event to decide if you want to enroll. You need to send your application and pay the premium. If this is completed on time, you have enrolled in COBRA.

When is your first premium payment due?
Your first premium payment must be made within 45 days after the date of the COBRA election.

How much will COBRA coverage cost?
For most COBRA qualifying events you and your dependents will pay 102% of the total plan costs. This additional 2% is added to cover administrative fees. If you apply for COBRA because of a disability, the total due will be 150% of the plan costs.

Can you add a dependent to your COBRA coverage?
You may add a new dependent during a period of COBRA coverage. They can be added for the rest of the COBRA coverage period if:
- They meet the definition of an eligible dependent.
- You notified the employer within 31 days of their eligibility.
- You pay the additional required premiums.

When does COBRA coverage end?
COBRA coverage ends if:
- Coverage has continued for the maximum period.
- The plan ends. If the plan is replaced, you may be continued under the new plan.
- You and your dependents fail to make the necessary payments on time.
- You or a covered dependent become covered under another group health plan that does not exclude coverage for pre-existing conditions or the pre-existing conditions exclusion does not apply. COBRA participants needs to notify the employer.
- You or a covered dependent become entitled to benefits under Medicare.
- You or your dependents are continuing coverage during the 19th to 29th months of a disability, and the disability ends.

Continuation of coverage for other reasons
To request an extension of coverage, just call the toll-free Member Services number on your ID card.

How can you extend coverage for hearing services and supplies when coverage ends?
If your coverage ends while you are not totally disabled, your plan will cover hearing services and supplies within 30 days after your coverage ends if:
- The prescription for the hearing aid is written in the 30 days before your coverage ended.
- The hearing aid is ordered during the 30 days before the date coverage ends.

How can you extend coverage for your disabled child beyond the plan age limits?
You have the right to extend coverage for your dependent child beyond the plan age limits. If your disabled child:
- Is not able to be self-supporting because of mental or physical disability, and
- Depends mainly (more than 50% of income) on you for support.
The right to coverage will continue only as long as a physician certifies that your child still is disabled.

We may ask you to send us proof of the disability within 90 days of the date coverage would have ended. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won’t ask for this proof more than once a year. You must send it to us within 31 days of our request. If you don’t, we can terminate coverage for your dependent child.
General provisions – other things you should know

Administrative information
Who’s responsible to you
We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your providers. Even network providers are not our employees or agents.

Coverage and services
Your coverage can change
Your coverage is defined by the group health policy. This document may have amendments too. Under certain circumstances, we or the customer or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive precertification, prescription quantity limits or your cost share if you are affected. Only Aetna may waive a requirement of your plan. No other person, including the policyholder or provider, can do this.

If a service cannot be provided to you
Sometimes things happen that are outside of our control. These are things such as natural disasters, epidemics, fire and riots.

We will try hard to get you access to the services you need even if these things happen. But if we can’t, we may refund you or the employer any unearned premium.

Legal action
You must complete the internal appeal process before you take any legal action against us for any expense or bill. See the When you disagree - claim decisions and appeal procedures section. You cannot take any action until 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations and evaluations
At our expense, we have the right to have a physician of our choice examine you. This will be done at all reasonable times while certification or a claim for benefits is pending or under review.

Records of expenses
You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:
  • Names of physicians, dentists and others who furnish services
  • Dates expenses are incurred
  • Copies of all bills and receipts

Honest mistakes and intentional deception
Honest mistakes
You or the customer may make an honest mistake when you share facts with us. When we learn of the mistake,
we may make a fair change in contributions or in your coverage. If we do, we will tell you what the mistake was. We won’t make a change if the mistake happened more than 2 years before we learned of it.

**Intentional deception**

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. This is called rescission.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

We also may report fraud to criminal authorities.

Rescission means you lose coverage both going forward and going backward. If we paid claims for your past coverage, we will want the money back.

You have special rights if we rescind your coverage.

- We will give you 30 days advanced written notice of any rescission of coverage.
- You have the right to an Aetna appeal.
- You have the right to a third party review conducted by an independent external review organization.

**Financial information**

**Assignment of benefits**

When you see a network provider they will usually bill us directly. When you see an out-of-network provider, we may choose to pay you or to pay the provider directly. Unless we have agreed to do so in writing and to the extent allowed by law, we will not accept an assignment to an out-of-network provider or facility under this plan. This may include:

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

**Financial sanctions exclusions**

If coverage provided under this booklet violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for eligible health services if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

**Recovery of overpayments**

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan’s third-party administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the
plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

**SUBROGATION AND RIGHT OF RECOVERY**

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

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

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

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

**Subrogation**

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

**Reimbursement**

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

**Constructive Trust**

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

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

**Assignment**

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

**First-Priority Claim**

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

**Applicability to All Settlements and Judgments**

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

**Cooperation**

You agree to cooperate fully with the plan’s efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.
You shall do nothing to prejudice the plan’s subrogation or recovery interest or prejudice the plan’s ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan’s subrogation and reimbursement interest.

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

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

**Interpretation**

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

**Jurisdiction**

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

**Sutter Health and Affiliates Services**

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna’s contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter’s services on an in-network basis.
Glossary

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

Ambulance
A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.

Body mass index
This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug
A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Copay/copayments
The specific dollar amount or percentage you have to pay for a health care service listed in the schedule of benefits.

Cosmetic
Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits
Eligible health services that meet the requirements for coverage under the terms of this plan, including:
  1. They are medically necessary.
  2. You received precertification if required.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Deductible
The amount you pay for eligible health services per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification
The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:
  • Intoxicating alcohol or drug
  • Alcohol or drug-dependent factors
  • Alcohol in combination with drugs
This can be done by metabolic or other means determined by a **physician** or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

**Directory**

The list of **network providers** for your plan. The most up-to-date directory for your plan appears at www.aetna.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for **providers** that participate in your specific plan. **Network providers** may only be considered for certain plans.

**Durable medical equipment (DME)**

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

**Effective date of coverage**

The date your and your dependent’s coverage begins under this booklet as noted in your employer's records.

**Eligible health services**

The health care services and supplies and **prescription drugs** listed in the *Eligible health services under your plan* section and not carved out or limited in the *exclusions* section or in the schedule of benefits.

**Emergency admission**

An admission to a **hospital** or treatment facility ordered by a **physician** within 24 hours after you receive **emergency services**.

**Emergency medical condition**

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, **illness** or **injury** is of a severe nature. And that if you don’t get immediate medical care it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

**Emergency services**

Treatment given in a **hospital**’s emergency room for an **emergency medical condition**. This includes evaluation of, and treatment to stabilize an **emergency medical condition**.
Experimental or investigational
A drug, device, procedure, or treatment that is found to be experimental or investigational because:
- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Formulary exclusions list
A list of prescription drugs not covered under the plan. This list is subject to change.

Generic prescription drug
A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Health professional
A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, and physical therapists.

Home health care agency
An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a physician or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound.

Hospice care
Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospice care agency
An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program
A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.
**Hospital**
An institution licensed as a **hospital** by applicable state and federal laws, and accredited as a **hospital** by The Joint Commission (TJC).

**Hospital** does not include a:
- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance abuse
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

**Illness**
Poor health resulting from disease of the body or mind.

**Infertile/infertility**
A disease defined by the failure to become pregnant:
- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart

**Injury**
Physical damage done to a person or part of their body.

**Institutes of Excellence™ (IOE) facility**
A facility designated by Aetna in the provider directory as Institutes of Excellence network provider for specific services or procedures.

**Intensive outpatient program (IOP)**
Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of medically necessary services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.
Jaw joint disorder
This is:
• A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint,
• A myofascial pain dysfunction (MPD) of the jaw, or
• Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.
A licensed practical nurse or a licensed vocational nurse.

Mail order pharmacy
A pharmacy where prescription drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit
The maximum out-of-pocket amount for payment of copayments and payment percentage including any deductible, to be paid by you or any covered dependents per Calendar Year for eligible health services.

Medically necessary/Medical necessity
Health care services that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
• In accordance with generally accepted standards of medical practice
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease
• Not primarily for the convenience of the patient, physician, or other health care provider
• 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

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.
• Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder
A mental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/morbidly obese
This means the body mass index is well above the normal range and severe medical conditions may also be present, such as:
• High blood pressure
• A heart or lung condition
• Sleep apnea or
• Diabetes
**Negotiated charge**

*For health coverage, this is either:*

- The amount a network provider has agreed to accept
- The amount we agree to pay directly to a network provider or third party vendor (including any administrative fee in the amount paid)

For providing services, prescription drugs or supplies to plan members. This does not include prescription drug services from a network pharmacy.

*For prescription drug services from a network pharmacy:*
The amount we established for each prescription drug obtained from a network pharmacy under this plan. This negotiated charge may reflect amounts we 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 us.

The negotiated charge does not reflect any amount an affiliate or we may receive under a rebate arrangement between us or an affiliate and a drug manufacturer for any prescription drug.

The rebates will not change the negotiated charge under this plan.

We 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 pharmacy that has contracted with Aetna, an affiliate, or a third party vendor, to provide outpatient prescription drugs to you.

**Network provider**

A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not a network provider.

**Non-preferred drug**

A prescription drug or device that may have a higher out-of-pocket cost than a preferred drug.

**Out-of-network pharmacy**

A pharmacy that is not a network pharmacy or a National Advantage Program (NAP) provider and does not appear in the directory for your plan.

**Out-of-network provider**

A provider who is not a network provider.

**Partial hospitalization treatment**

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance abuse issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring
Care is delivered according to accepted medical practice for the condition of the person.

Payment Percentage
The specific percentage the plan pays for a health care service listed in the schedule of benefits.

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

Physician
A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify
A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Preferred drug
A prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

Preferred drug guide
A list of prescription drugs and devices established by Aetna or an affiliate. It does not include all prescription drugs and devices. This list can be reviewed and changed by Aetna or an affiliate. A copy of the preferred drug guide is available at your request. Or you can find it on the Aetna website at www.aetna.com/formulary.

Preferred network pharmacy
A network retail pharmacy that Aetna has identified as a preferred network pharmacy.

Prescriber
Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription
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 network pharmacy.

Prescription drug
An FDA approved drug or biological which can only be dispensed by prescription.

Primary care physician (PCP)
A physician who:
- The directory lists as a PCP
- Is selected by a person from the list of PCPs in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care physician, an internist, a pediatrician
- Is shown on Aetna's records as your PCP
**Provider(s)**
A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

**Psychiatric hospital**
An institution specifically licensed or certified as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, mental disorders (including substance-related disorders) or mental illnesses.

**Psychiatrist**
A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

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

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

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Recognized charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services and other services or supplies not mentioned below</td>
<td>The reasonable amount rate</td>
</tr>
<tr>
<td>Services of hospitals and other facilities</td>
<td>The reasonable amount rate</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>110% of the average wholesale price (AWP)</td>
</tr>
</tbody>
</table>

**Important note:** If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Recognized charge does not apply to involuntary services.

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

**Special terms used**
- Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider’s estimated costs for the service and leave the facility provider with a reasonable profit. For hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the recognized charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
• Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

• Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
  - Not available from a network provider
  - Emergency services

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

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

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

• “Reasonable amount rate” means your plan has established a reasonable rate amount as follows:

<table>
<thead>
<tr>
<th>Service or supply</th>
<th>Reasonable amount rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional services</td>
<td>80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically:</td>
</tr>
<tr>
<td></td>
<td>• We update our systems with these changes within 180 days after receiving them from FAIR Health</td>
</tr>
<tr>
<td></td>
<td>• If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable</td>
</tr>
<tr>
<td></td>
<td>If the alternative data source does not contain a value for a particular service or supply, we will base the recognized charge on the Medicare allowed rate.</td>
</tr>
<tr>
<td>Inpatient and outpatient charges of hospitals</td>
<td>The Facility charge rate (FCR) rate</td>
</tr>
<tr>
<td>Inpatient and outpatient charges of facilities other than hospitals</td>
<td>The Facility charge rate (FCR) rate</td>
</tr>
</tbody>
</table>
Our reimbursement policies
We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge.

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

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

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

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

R.N.
A registered nurse.

Residential treatment facility (mental disorders)
- An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:
- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a psychiatrist at least once per week.
- The medical director must be a psychiatrist.
• Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

Residential treatment facility (substance abuse)
• An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:
  - The Joint Commission (TJC)
  - The Committee on Accreditation of Rehabilitation Facilities (CARF)
  - The American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP)
  - The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:
• A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
• The medical director must be a physician who is an addiction specialist.
• Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:
• An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting.
• Residential care must be provided under the direct supervision of a physician.

Retail pharmacy
A community pharmacy that dispenses outpatient prescription drugs at retail prices.

Room and board
A facility’s charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate
An institution’s room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:
• Minimal care
• Custodial care services
• Ambulatory care
• Part-time care services
It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.

**Skilled nursing services**
Services provided by an R.N. or L.P.N. within the scope of their license.

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

**Specialty prescription drugs**
These are prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration.

You can access the list of these specialty prescription drugs by calling the toll-free number on your ID card or by logging on to your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com).

**Specialty pharmacy**
This is a pharmacy designated by Aetna as a network pharmacy to fill prescriptions for specialty prescription drugs.

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

**Substance abuse**
This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a mental disorder that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

**Surgery center**
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

**Surgery or surgical procedures**
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, laser, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

**Telemedicine**
A consultation between you and a provider who is performing a clinical medical or behavioral health service.

Services can be provided by:
- Two-way audiovisual teleconferencing;
- Telephone calls, except for behavioral health services
- Any other method required by state law
Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

Therapeutic drug class
A group of drugs or medications that have a similar or identical mode of action. Or are used for the treatment of the same or similar disease or injury.

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

Urgent condition
An illness or injury that requires prompt medical attention but is not an emergency medical condition.

Walk-in clinic
A free-standing health care facility. Neither of the following should be considered a walk-in clinic:
- An emergency room
- The outpatient department of a hospital
Discount programs

Discount arrangements
We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don’t pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.
Additional Information Provided by

University of Hartford

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

**Name of Plan:**
University of Hartford Welfare Plan

**Employer Identification Number:**
06-0731360

**Plan Number:**
501

**Type of Plan:**
Welfare

**Type of Administration:**
Administrative Services Contract with:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:**
University of Hartford  
200 Bloomfield Ave.  
West Hartford, CT 06117

Telephone Number: (860) 768-4156

**Agent For Service of Legal Process:**
University of Hartford  
200 Bloomfield Ave.  
West Hartford, CT 06117

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

**End of Plan Year:**
December 31

**Source of Contributions:**
Employer and Employee
Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Plan Administrator.

ERISA Rights
As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

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

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

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

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.