BENEFIT PLAN

Prepared Exclusively for
State of Ohio - Ohio Med Plan

What Your Plan Covers and How Benefits are Paid

Aetna Choice POS II
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*Defines the Terms Shown in Bold Type in the Text of This Document.
Preface

The medical benefits plan described in this Booklet is a benefit plan of the State of Ohio. These benefits are not insured with Aetna or any of its affiliates, but will be paid from the State of Ohio's funds. Aetna and its HMO affiliates will provide certain administrative services under the Aetna medical benefits plan.

Aetna agrees with the State of Ohio to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this Booklet. The State of Ohio selects the products and benefit levels under the Aetna medical benefits plan.

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

This Booklet replaces and supersedes all Aetna Booklets describing coverage for the medical benefits plan described in this Booklet that you may previously have received.

Employer: State of Ohio  
Contract Number: 285507  
Effective Date: July 1, 2017  
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Booklet Number: 1

Coverage for You and Your Dependents

Health Expense Coverage

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

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

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

Treatment Outcomes of Covered Services

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

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

Who Is Eligible

Employees

Eligibility Requirements

Employee Eligibility
You are eligible for health care benefits if you are a permanent full-time employee, permanent part-time employee, or a part-time temporary employee who averages at least 30 hours of service per week over a twelve-month measurement period.

State of Ohio employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Married State Employees
When both spouses in a family are employed by the State, each may elect single coverage, or one may elect family coverage provided that the spouse who elects single coverage may not be listed as a dependent under the family coverage. A child who is eligible as an employee of the State is not also eligible as the dependent of a parent who is also a State employee, except as required by the PPACA.

Dependent Eligibility
Family members as described below may be eligible for coverage under your medical coverage:
(Please go to: das.ohio.gov/eligibility requirements for the Definitions and Required Documents checklist for documentation required to enroll a dependent).

1. Spouse. Your current legal spouse as recognized by Ohio law.
2. Children under Age 26 including:
   • Your biological children (married or unmarried)
   • Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
   • Your dependent stepchildren
   • Foster children
   • Children for whom either you or your spouse has been appointed legal guardian
   • Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the QMCSO

Note: Dependent children are only eligible for dental/vision benefits if unmarried and under age 23. Dependent children ages 19-22 with dental/vision coverage must be a student.
3. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to intellectual disability, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for this plan. The form can be found at das.ohio.gov/healthplanforms

Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 26 and older
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- A spouse from a common law marriage established in Ohio after October 10, 1991
- Any other members of your household who do not meet the definition of an eligible dependent
- A child who is eligible as an employee of the State is not also eligible as the dependent of a parent who is also a State employee, except as required by the Patient Protection and Affordable Care Act.

It is the employee's responsibility to disenroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Card Holders if a medical child support order is received. The Group will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Group will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.
Effective Date
Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is typically the first day of the month following your hire date. The effective date for enrollment or changes made during open enrollment is typically July 1. No benefits will be provided for services, supplies or charges Incurred before your Effective Date.

Changes in Coverage
If you have individual coverage, you may change to family coverage if you marry or you or your spouse acquire an Eligible Dependent. You must notify your benefits specialist who must then notify Aetna of the change.

Coverage for a spouse and other dependents who become eligible by reason of marriage will be effective on the first of the month following the date of the marriage if a request for their coverage is submitted to the Group within 31 days of the marriage. A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment Form promptly.

There are occasions when circumstances change and only the Card Holder is eligible for coverage. Family coverage must then be changed to individual coverage. In addition, the Group must be notified when you or an Eligible Dependent under your Benefit Book becomes eligible for Medicare.

Special Enrollment
For information regarding eligible changes outside of open enrollment, please go to the State of Ohio's website at:http://das.ohio.gov/benefits and click the link on the right entitled "Change In Status/Qualifying Events Matrix".
When Your Coverage Begins

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

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

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

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

Note: New dependents need to be reported to the State of Ohio within 31 days because they may affect your contributions. If you do not report a new dependent within 31 days of his or her eligibility date, the rules under the Special Enrollment section will apply.
How Your Medical Plan Works

Common Terms
Accessing Providers
Precertification

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

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

Important Notes

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

Common Terms

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

About Your Aetna Choice POS II Medical Plan

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

Important Note

Network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members. Network providers are generally identified in the printed directory and the on-line version of the directory via DocFind at www.aetna.com unless otherwise noted in this section. Out-of-network providers are not listed in the Aetna directory.

The plan will pay for covered expenses up to the maximum benefits shown in this Booklet.

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

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

You also have the choice to access licensed providers, hospitals and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use out-of-network providers because the deductibles, copayments, and payment percentage that you are required to pay are usually higher when you utilize out-of-network providers. Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna pays under the plan.

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

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

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

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

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

How Your Aetna Choice POS II Medical Plan Works

The Primary Care Physician:
To access network benefits, you are encouraged to select a Primary Care Physician (PCP) from Aetna’s network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf. (Selecting a PCP is not a requirement of this Plan)

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

A PCP may be a general practitioner, family physician, internist, or pediatrician. Your PCP provides routine preventive care and will treat you for illness or injury.
A PCP coordinates your medical care, as appropriate either by providing treatment or may direct you to other network providers for other covered services and supplies. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

Changing Your PCP
You may change your PCP at any time on Aetna’s website, www.aetna.com, or by calling the Member Services toll-free number on your identification card. The change will become effective upon Aetna’s receipt and approval of the request.

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

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

Accessing Network Providers and Benefits

- You may select a PCP or other direct access network provider from the network provider directory or by logging on to Aetna’s website at www.aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of physicians, hospitals and other health care providers and facilities. You can change your PCP at any time.
- If a service or supply you need is covered under this Plan but not available from a network provider in your area, your PCP may refer you to an out-of-network provider. As long as your PCP has provided you with a referral that has been approved by Aetna, you will receive the network benefit level as shown in your Schedule of Benefits.
- If a service or supply you need is covered under this Plan but not available from a network provider in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification with Aetna to verify coverage for these services. You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider’s responsibility, there are no additional out-of-pocket costs to you as a result of a network provider’s failure to precertify services. Refer to the Understanding Precertification section for more information on the precertification process and what to do if your request for precertification is denied.
- Except for your prescription drug expenses, you will not have to submit medical claims for treatment received from network health care professionals and facilities. Your network provider will take care of claim submission. Aetna will directly pay the network provider or facility less any cost sharing required by you. You will be responsible for deductibles, payment percentage and copayments, if any.
- You may be required to pay some network providers at the time of service. When you pay a network provider directly, you will be responsible for completing a claim form to receive reimbursement of covered expenses from Aetna. You must submit a completed claim form and proof of payment to Aetna. Refer to the General Provisions section of this Booklet for a complete description of how to file a claim under this Plan.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe towards your deductible, copayments, or payment percentage or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.
Cost Sharing For Network Benefits

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

- Network providers have agreed to accept the negotiated charge. Aetna will reimburse you for a covered expense, incurred from a network provider, up to the negotiated charge and the maximum benefits under this Plan, less any cost sharing required by you such as deductibles, copayments and payment percentage. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply.
- You must satisfy any applicable deductibles before the plan will begin to pay benefits.
- Deductibles and payment percentage are usually lower when you use network providers than when you use out-of-network providers.
- For certain types of services and supplies, you will be responsible for any copayments shown in your Schedule of Benefits. The copayments will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a specialist or non-specialist. You will be subject to the PCP copayments shown on the Schedule of Benefits when you obtain covered health care services from any PCP who is a network provider. If the provider is a network specialist, then the specialist copayment will apply.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.
- Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limits for the rest of the Plan Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limits. Refer to your Schedule of Benefits for information on what covered expenses do not apply to the maximum out-of-pocket limits and for the specific maximum out-of-pocket limit amounts that apply to your plan.
- The plan will pay for covered expenses, up to the benefit maximums shown in the What the Plan Covers section or the Schedule of Benefits. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers section or the Schedule of Benefits.
- You may be billed for any deductible, copayment, or payment percentage amounts, or any non-covered expenses that you incur.

Accessing Out-of-Network Providers and Benefits

- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification with Aetna to verify coverage for these services. When you receive services from an out-of-network provider, you are responsible for obtaining the necessary precertification from Aetna. Your provider may precertify the services for you. However, you should verify with Aetna prior to the service, that the provider has obtained precertification from Aetna. If the service is not precertified, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the precertification toll-free number on your ID card to precertify services. Refer to the Understanding Precertification section for more information on the precertification process and what to do if your request for precertification is denied.
- When you use out-of-network providers, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to Aetna for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of covered expenses that you paid directly to an out-of-network provider.
- When you pay an out-of-network provider directly, you will be responsible for completing a claim form to receive reimbursement of covered expenses from Aetna. You must submit a completed claim form and proof of payment to Aetna. Refer to the General Provisions section of this Booklet for a complete description of how to file a claim under this plan.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe towards any deductible, or payment percentage amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.
Important Note
Failure to precertify services and supplies will result in a reduction of benefits or no coverage for the services or supplies under this Booklet. Please refer to the Understanding Precertification section for information on how to request precertification.

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

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

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

You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider’s responsibility, there is no additional out-of-pocket cost to you as a result of a network provider’s failure to precertify services.

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

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

The Precertification Process
Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.
You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification pursuant to this Booklet in accordance with the following timelines:

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

<table>
<thead>
<tr>
<th>Precertification Type</th>
<th>Timeframe Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-emergency admissions:</td>
<td>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.</td>
</tr>
<tr>
<td>For an emergency outpatient medical condition:</td>
<td>You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.</td>
</tr>
<tr>
<td>For an emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission:</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

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

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

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

**Services and Supplies Which Require Precertification**

Precertification is required for the following types of medical expenses. You do not need to precertify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider’s responsibility, there is no additional out-of-pocket cost to you as a result of a network provider’s failure to precertify services.

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

**Inpatient and Outpatient Care**

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Applied Behavioral Analysis;
- Neuropsychological testing;
- Psychological testing.

**How Failure to Precertify Affects Your Benefits**

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

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

**How Your Benefits are Affected**

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

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

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

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

**Emergency and Urgent Care**

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

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

**In Case of a Medical Emergency**

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

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

**Coverage for Emergency Medical Conditions**

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

**Important Reminder**

If you visit a hospital emergency room for a non-emergency condition, the plan will pay the benefit, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

**In Case of an Urgent Condition**

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

If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna’s online provider directory at www.aetna.com.

**Coverage for an Urgent Condition**

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

**Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition**

Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for illness or injury. If you access a hospital emergency room for follow-up care, your coverage will be paid. Refer to your Schedule of Benefits for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a physician.

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

**Important Notice**

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

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

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

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

3. The service or supply must be medically necessary. To meet this requirement, the medical services or supply must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
   - 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; and
   - Not primarily for the convenience of the patient, physician or other health care provider;
   - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

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

Important Note

Not every service or supply that fits the definition for medical necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the What the Plan Covers section and the Schedule of Benefits for the plan limits and maximums.
What The Plan Covers

Aetna Choice POS II Medical Plan

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

Preventive Care

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

Important Notes:

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

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

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

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

Routine Physical Exams

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

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

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

Preventive Care Immunizations
Covered expenses include charges made by your physician or a facility for:
- immunizations for infectious diseases; and
- the materials for administration of immunizations;

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

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

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

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

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

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

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

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

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

Limitations:

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

- Services which are covered to any extent under any other part of this Plan.

Important Notes:

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

Screening and Counseling Services

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

Obesity and/or Healthy Diet

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

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

Misuse of Alcohol and/or Drugs

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

Use of Tobacco Products

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

- preventive counseling visits;
- treatment visits; and
- class visits;
to aid in the cessation of the use of tobacco products.

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

**Genetic Risks for Breast and Ovarian Cancer**
Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

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

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

- Services which are covered to any extent under any other part of this Plan.

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

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

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

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

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

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

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

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

**Covered expenses** include the following:

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

Breast Pump Supplies

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

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

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

**Limitations:**

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

Family Planning Services - Female Contraceptives

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

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

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

**Voluntary Sterilization**

**Covered expenses** include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

**Covered expenses** under this Preventive Care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.

**Contraceptives**

**Covered expenses** include charges made by a physician for:

- Services and supplies needed to administer or remove a covered contraceptive prescription drug or device;
- Female injectable contraceptives that are generic **prescription drugs**;
- Female contraceptives devices that are generic devices and brand name devices.

**Limitations:**

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

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

**Family Planning Services - Other**

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

- Voluntary sterilization for males

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

**Important Notes:**

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

**Vision Care Services**

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

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam up to age 21 that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

**Limitations**

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

**Hearing Exam**

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

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

All covered expenses for the hearing exam are subject to any applicable deductible, copay and payment percentage shown in your Schedule of Benefits.
Physician Services

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

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

Surgery
Covered expenses include charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion prior to the surgery.

Anesthetics
Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

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

Alternatives to Physician Office Visits

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

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

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

- In a group setting for screening and counseling services.

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

Hospital Expenses

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

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

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

Outpatient Hospital Expenses

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

Important Reminders

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

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

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

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

Refer to the Schedule of Benefits for any applicable deductible, copay and payment percentage and maximum benefit limits.
Coverage for Emergency Medical Conditions
Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

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

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

Important Reminder
With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will pay the benefit, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions
Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your PCP after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will pay the benefit, as shown in the Schedule of Benefits.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services
Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A physician or dentist for professional services;
- A surgery center, or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital and
- The surgery is not normally performed in a physician’s or dentist’s office.
Important Note
Benefits for surgery services performed in a physician's or dentist's office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital, surgery center on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

Limitations
Not covered under this plan are charges made for:

- The services of a physician or other health care provider who renders technical assistance to the operating physician.
- A stay in a hospital.
- Facility charges for office based surgery.

Birthing Center
Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

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

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See Pregnancy Related Expenses for information about other covered expenses related to maternity care.

Home Health Care
Covered expenses include charges made by a home health care agency for home health care, and the care:

- Is given under a home health care plan;
- Is given to you in your home while you are homebound.

Home health care expenses include charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had a hospital stay.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is 1 visit.
In figuring the Plan Year Maximum Visits, each visit of:

Nurse or Therapist, up to 4 hours is 1 visit
This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

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

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

**Limitations**

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

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your, your spouse’s family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

**Important Reminders**

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

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

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

**Skilled Nursing Care**

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

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

Covered expenses also include private duty nursing provided by a R.N. or L.P.N. if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a Plan Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

**Limitations**

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

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

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

- **Room and board**, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
- Medical supplies.

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

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

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

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

Hospice Care
Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.
Facility Expenses
The charges made by a hospital, hospice or skilled nursing facility for:

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

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

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

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - Prescription drugs;
  - Psychological counseling; and
  - Dietary counseling.

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

- Daily room and board charges over the semi-private room rate.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminders
Refer to the Schedule of Benefits for details about any applicable hospice care maximums.

Inpatient hospice care and home health care must be precertified by Aetna. Refer to How the Plan Works for details about precertification.
Ambulance Service
Covered expenses include charges made by a professional ambulance, as follows:

Ground Ambulance
Covered expenses include charges for transportation:

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

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

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

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

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

**Covered expenses** include charges made by a **physician** or **behavioral health provider** for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits but **excluding** Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a **physician**, licensed psychologist, or licensed clinical social worker, as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

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

**Diagnostic and Preoperative Testing**

**Diagnostic Complex Imaging Expenses**

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

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds $500.

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

**Limitations**

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

**Outpatient Diagnostic Lab Work and Radiological Services**

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

**Important Reminder**

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

**Outpatient Preoperative Testing**

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

- Related to your surgery, and the surgery takes place in a **hospital** or **surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital** or **surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital** or **surgery center** where the surgery is performed.
Limitations
The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

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

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

Durable Medical and Surgical Equipment (DME)

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

The initial purchase of DME if:

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

Replacement of purchased equipment if:

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

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

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

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

Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)

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

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

An “approved clinical trial” is a clinical trial that meets these criteria:
The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.

The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.

The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.

The trial conforms to standards of the NCI or other, applicable federal organization.

The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.

You are treated in accordance with the protocols of that study.

**Routine Patient Costs**

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

**Limitations:**

Not covered under this Plan are:

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

**Important Note:**

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

**Pregnancy Related Expenses**

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

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

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

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

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

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

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

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

**Covered expenses** also include replacement of a prosthetic device if:

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

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

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

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

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

**Hearing Aids**

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

Benefits are payable up to the hearing aid maximum listed in the Schedule of Benefits.

All **covered expenses** are subject to the hearing expense exclusions in this *Booklet* and are subject to **deductible(s)**, **copayments** or **payment percentage** listed in the *Schedule of Benefits*, if any.
Short-Term Rehabilitation Therapy Services

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

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility, or hospice facility; or
- A physician.

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits.

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

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

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Booklet.

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function. Additionally, coverage for physical therapy is available for the treatment of Cerebral Palsy and Down Syndrome diagnoses.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function. Additionally, coverage for occupational therapy is available for the treatment of Cerebral Palsy and Down Syndrome diagnoses.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one’s thoughts with spoken words. Additionally, coverage for speech therapy is available for the treatment of Cerebral Palsy and Down Syndrome diagnoses.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A “visit” consists of no more than one hour of therapy. Refer to the Schedule of Benefits for the visit maximum that applies to the plan. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.
The therapy should follow a specific treatment plan that:

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

**Important Reminder**

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

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

- Therapies for the treatment of delays in development, unless resulting from acute *illness* or *injury*, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Development Disorders, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders, Cerebral Palsy or Down Syndrome.
- Any services which are *covered expenses* in whole or in part under any other group plan sponsored by the State of Ohio;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from *illness, injury*, or congenital defect;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services provided by a home health care agency;
- Services not performed by a *physician* or under the direct supervision of a physician;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

**Reconstructive or Cosmetic Surgery and Supplies**

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

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

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

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

**Reconstructive Breast Surgery**

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.
Important Notice
A benefit maximum may apply to reconstructive or cosmetic surgery services. Please refer to the Schedule of Benefits.

Specialized Care

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

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

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

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling 1-800-949-3104.

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

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

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

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

These benefits are not covered under the Infusion Therapy benefit. When medically necessary, these benefits may be covered under other benefit provisions within the plan.

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

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

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.
Important Reminder
Refer to the Schedule of Benefits for details about any applicable deductible, coinsurance and maximum benefit limits.

Specialty Care Prescription Drugs
Covered expenses include specialty care prescription drugs when they are:

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

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

- Insulin preparations;
- Internal and External insulin pumps and supplies, including:
  - Reservoirs and cartridges
  - Insertion devices
  - Infusion sets
  - Batteries (Lithium only)
- Continuous glucose monitoring equipment, including:
  - Sensors
  - Sensor insertion devices
  - Sensor pads
  - Replacement parts
- Injection aids for the blind;
- Blood glucose monitors without special features unless required due to blindness;
- Liquid adhesive and adhesive remover wipes;
- Tapes, adhesive patches, dressings, and film;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility

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

Spinal Manipulation Treatment (Chiropractic Treatment)

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.
Transplant Services

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

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

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

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

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

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

The plan covers:

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

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

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

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

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

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

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

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

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

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

**Covered expenses** include charges made by a physician, licensed or certified dietician, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and

**Morbid Obesity Surgical Expenses**

Covered medical expenses include charges made by a hospital or a physician for the surgical treatment of morbid obesity of a covered person.

Coverage includes the following expenses as long as they are incurred within a two-year period:
- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

Benefit includes coverage for gastric by-pass surgery and bariatric surgery. Specific medical clinical criteria must be met as outlined in the Aetna Clinical Policy Bulletins.

**Limitations**

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

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Booklet; and.
- Services which are covered to any extent under any other part of this Plan.

**Important Reminder**

Refer to the Schedule of Benefits for information about any applicable benefit maximums that apply to morbid obesity treatment.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

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

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

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

**Hospital** services and supplies received for a stay required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed due to injury.
(b) Other body tissues of the mouth fractured or cut due to injury.

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

The treatment must be completed in the Plan Year of the accident or in the next Plan Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

**Medical Plan Exclusions**

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the **What the Plan Covers** section. Charges made for the following are not covered except to the extent listed under the **What The Plan Covers** section or by amendment attached to this Booklet.

1) Acupuncture, acupressure and acupuncture therapy, except as provided in the **What the Plan Covers** section.

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

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

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

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

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

6) **Behavioral Health Services**:

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

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

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

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

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

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

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

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

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

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

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

15) Court ordered services, including those required as a condition of parole or release.
16) Custodial Care (see complete definition on page 62)

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

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants (except when due to an accidental injury or medical condition [example tumor removal]. Coverage is subject to medical necessity review);
- false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

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

19) Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications;
- Any prescription drugs, injectibles, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

20) Educational services:

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

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

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

23) Facility charges for care services or supplies provided in:

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

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

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

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

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

27) Hearing:

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

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

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

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

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

30) Maintenance Care.

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

32) Miscellaneous charges for services or supplies including:

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

Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

33) Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

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

35) Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

36) Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
   - Surgical procedures to alter the appearance or function of the body;
   - Hormones and hormone therapy;
   - Prosthetic devices; and
   - Medical or psychological counseling.

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

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

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

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

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

42) Services that are not covered under this Booklet.

43) Services and supplies provided in connection with treatment or care that is not covered under the plan.

44) Speech therapy for treatment of delays in speech development, except as specifically provided in the What the Medical Plan Covers Section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

45) Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused
by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

46) **Strength and performance:** Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat *illnesses, injuries* or disabilities related to the use of performance-enhancing drugs or preparations.

47) **Therapies for the treatment of delays in development,** unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered.

48) **Therapies and tests:** Any of the following treatments or procedures:

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

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

50) **Transplant-** The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing *illness*;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing *illness*;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise *precertified* by Aetna.
51) Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in the *What the Plan Covers* section.

52) Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

53) Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

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

54) Voluntary termination of pregnancy, including related services.

55) Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:

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

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

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

58) This plan excludes coverage for collagen cross-linking of the cornea. This includes the removal of the corneal epithelium and intraoperative pachymetry when performed.
When Coverage Ends

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

When Coverage Ends for Employees
Your Aetna health benefits coverage will end if:

- The Aetna health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You become covered under another plan offered by the State of Ohio; or
- The State of Ohio notifies Aetna that your employment is ended.

It is the State of Ohio’s responsibility to let Aetna know when your employment ends.

When Coverage Ends for Dependents
Coverage for your dependents will end if:

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

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

Continuation of Coverage

Continuing Health Care Benefits

Handicapped Dependent Children
Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

## COBRA Continuation of Coverage

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

### Continuing Coverage through COBRA

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

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of the State of Ohio’s notice of this COBRA continuation right, if later.
- Agree to pay the required contributions.

### Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA or within 60 days of the State of Ohio’s notice of the COBRA continuation right. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.
Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

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

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

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

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

If There Are Multiple Qualifying Events

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

Determining Your Contributions For Continuation Coverage

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

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the plan costs.
When You Acquire a Dependent During a Continuation Period
If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- The State of Ohio is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation (where applicable) are paid on a timely basis.

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

When Your COBRA Continuation Coverage Ends
Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required contributions.
- You or your covered dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the continuation coverage under this plan may remain in effect until the preexisting clause ceases to apply or the maximum continuation period is reached under this plan.
- The date the State of Ohio no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.
Coordination of Benefits - What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
c. If there is not such a court decree:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:
- laid-off or retired employee; or
- the dependent of such person.

Shall be determined after the benefits of any other plan which covers such person as:
- an employee who is not laid-off or retired; or
- dependent of such person.

If the other plan does not have a provision:
- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:
- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.
**Other Plan**

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.
When You Have Medicare Coverage

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

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

You are eligible for Medicare if you are:

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

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

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

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

When Medicare is Primary

Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration.
**Aetna** will calculate the benefits the **plan** would pay in the absence of **Medicare**:

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

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

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

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

**Right to Receive and Release Required Information**

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

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

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

Financial Sanctions Exclusions

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

Assignments

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

Aetna’s failure to implement or insist upon compliance with any provision of this plan at any given time or times, shall not constitute a waiver of Aetna’s right to implement or insist upon compliance with that provision at any other time or times.

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

Rescission of Coverage

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

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

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

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

Subrogation and Right of Recovery Provision

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

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

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

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

Subrogation

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

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

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

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

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

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

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

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

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

**Interpretation**

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.

**Workers’ Compensation**

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

The Recovery Rights will be applied even though:

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

You hereby agree that, in consideration for the coverage provided by this Aetna medical benefits plan, you will notify Aetna of any Workers' Compensation claim you make, and that you agree to reimburse Aetna, on behalf of the Plan, as described above.

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

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

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

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

Reporting of Claims
A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. The State of Ohio has claim forms.

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

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

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

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

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

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

Very important are:

- Names of physicians, dentists and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.
Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Discount Programs

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

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

Claims, Appeals and External Review

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

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

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

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

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).
Other Claims (Pre-Service and Post-Service)
If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

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

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

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

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

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

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

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

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

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

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

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

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

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

Full and Fair Review of Claim Determinations and Appeals

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

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

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

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

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

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.
If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

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

Health Claims – Voluntary Appeals

External Review

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

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

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

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

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

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

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

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

Request for External Review

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

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

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

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.
An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

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

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

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

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

(i) Your medical records;
(ii) The attending health care professional's recommendation;
(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
(iv) The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
(vi) Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
(vii) The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.
After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.
Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

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

(a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

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

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

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

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

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

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

**Behavioral Health Provider/Practitioner**
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

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

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

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

**Copay or Copayment**
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the *Schedule of Benefits*. 
Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.

Custodial Care
Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

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

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

Deductible
The part of your covered expenses you pay before the plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in the Schedule of Benefits.

Dentist
A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Detoxification
The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.
Directory
A listing of all network providers serving the class of employees to which you belong. The contractholder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

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

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency Care
This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

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

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

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

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

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

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

Home Health Care Agency
An agency that meets all of the following requirements.

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

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

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

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

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

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
Develops a **hospice care program** to meet those needs.

Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.

Permits all area medical personnel to utilize its services for their patients.

Keeps a medical record on each patient.

Uses volunteers trained in providing services for non-medical needs.

Has a full-time administrator.

### Hospice Care Program

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

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

### Hospice Facility

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

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

### Hospital

An institution that:

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

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

### Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.
Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

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

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

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

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

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

Jaw Joint Disorder
This is:

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

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

Maintenance Care
Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit
Your plan has a maximum out-of-pocket limit. Your deductibles, payment percentage, copays and other eligible out-of-pocket expense apply to the maximum out-of-pocket limit. Once you satisfy the maximum amount the plan will pay 100% of covered expenses that apply toward the limit for the rest of the Plan Year. The maximum out-of-pocket limit applies to both network and out-of-network out-of-pocket expenses.
Medically Necessary or Medical Necessity
These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

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

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

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

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

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

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

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

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

Morbid Obesity
This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.
Negotiated Charge
The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

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

Network Provider
A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Aetna's consent, included in the directory as a network provider for:

- The service or supply involved; and
- The class of employees to which you belong.

Network Service(s) or Supply(ies)
Health care service or supply that is:

- Furnished by a network provider; or
- Furnished or arranged by your PCP.

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

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

Non-Occupational Illness
A non-occupational illness is an illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

Non-Specialist
A physician who is not a specialist.

Non-Urgent Admission
An inpatient admission that is not an emergency admission or an urgent admission.
Occupational Injury or Occupational Illness
An injury or illness that:

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

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

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

Orthodontic Treatment
This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

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

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

Payment Percentage
Payment percentage is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the “plan payment percentage,” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on payment percentage amounts.

Pharmacy
An establishment where prescription drugs are legally dispensed. Pharmacy includes a retail pharmacy, mail order pharmacy and specialty pharmacy network pharmacy.
Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

Precertification or Precertify
A process where Aetna is contacted before certain services are provided, such as hospitalization or outpatient surgery, or prescription drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered covered expenses under the plan. It is not a guarantee that benefits will be payable.

Prescriber
Any physician or dentist, acting within the scope of his or her license, who has the legal authority to write an order for a prescription drug.

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

Prescription Drug
A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

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

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

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician
This is a physician who:

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

Recognized Charge
The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above the recognized charge. The recognized charge may be less than the provider’s full charge.

Your plan’s recognized charge applies to all out-of-network covered expenses except out of network emergency services. It applies even to charges from an out-of-network provider in a hospital that is a network provider. It also applies when your PCP or other network provider refers you to an out-of-network provider. In all cases, the recognized charge is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and:

- For professional services and for other services or supplies not mentioned below:
  - The reasonable amount rate

The recognized charge is the negotiated charge for providers with whom we have a direct contract but are not network providers or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of Aetna.
If your ID card displays the National Advantage Program (NAP) logo, the **recognized charge** is the rate we have negotiated with your NAP provider. Your out-of-network cost sharing applies when you get care from NAP providers, except for emergency services.

A NAP provider is a **provider** with whom we have a contract through any third party that is not an affiliate of Aetna or through the Coventry National or First Health Networks. However, a NAP provider listed in the NAP directory is not a network provider.

We have the right to apply Aetna reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

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

Aetna reimbursement policies are based on our review of:

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

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Special terms used
Geographic area and Reasonable amount rate are defined as follows:

**Geographic area**
The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

**Reasonable amount rate:**
There is not a single “reasonable” amount. Your plan establishes the “reasonable” amounts as follows:

- For professional services:
  - The 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we reserve the right to substitute an alternative. 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 allowable rate.

**Additional information:**
Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna’s secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.
Rehabilitation Facility
A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

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

R.N.
A registered nurse.

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

Semi-Private Room Rate
The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
This is the geographic area, as determined by Aetna, in which network providers for this plan are located.

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

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

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.
Skilled nursing facility does not include:

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

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

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

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

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

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

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

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

Must have all of the following:

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

**Terminally Ill (Hospice Care)**

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

**Urgent Admission**

A hospital admission by a physician due to:

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

**Urgent Care Facility**

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

**Urgent Care Provider**

This is:

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

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

**Urgent Condition**

This means a sudden illness, injury, or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

**Walk-in Clinic**

Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for
treatment of:
- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither:
- An emergency room; nor
- The outpatient department of a hospital;

shall be considered a Walk-in Clinic.
IMPORTANT HEALTH CARE REFORM 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 the State of Ohio 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 the State of Ohio or, if you are a current member, your Aetna contact number on the back of your ID card.

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.

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 the State of Ohio grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by the State of Ohio.

If the State of Ohio 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 FMLA leave, you must agree to make any contributions required by the State of Ohio to continue coverage.

If any coverage the State of Ohio allows you to continue has reduction rules applicable by reason of age or retirement, the coverage 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 the State of Ohio 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 the State of Ohio.

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 the State of Ohio, 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 this Plan 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 the State of Ohio 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 the State of Ohio following the date the State of Ohio determines the approved FMLA leave is terminated, your coverage under this Plan 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 the State of Ohio determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because the State of Ohio 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 the State of Ohio determines the approved FMLA leave is terminated.
**Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

**Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

**Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services in conjunction with the role it plays as third party administrator, to people with disabilities to communicate effectively with Aetna staff, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services in conjunction with the role it plays as third party administrator, or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY
711, Fax 860-262-7705, CRCordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.

**Language Assistance**

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)
Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862. (Spanish)

欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

T’aá shi shizaad k’ehji bee shiká a’doowol nínízingo Diné k’ehji kojí t’aá jiijk’e hólné 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistence në gjuhën shqipe telefononi falas në 1-888-982-3862. (Albanian)

 cámara (Amharic)

نْذ لِلمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862. (Arabic)

Lhulhul qaumghaum muugu guqamaquma (hvufhla) quhla 1-888-982-3862 unwulq qum; (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তা জন্য বিনামূল্যে 1-888-982-3862 -এ কল করুন। (Bengali-Bangala)
Per rebre assistência en (català), truqui al número gratuit 1-888-982-3862 . (Catalan)

Para ayuda gi fino’ (Chamoru), ågang 1-888-982-3862 sin gástu. (Chamorro)

Gargaarsa afaan Oromo hii kuu argachuu lakk Kokofsa bilbila 1-888-982-3862 irratti bilisaa bilbila. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862 . (Dutch)

Pou jwenn assistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis. (French Creole)

Giα γλώσσακη βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση. (Greek)

No ke kôkua ma ka ‘ōlelo Hawai’i, e kahea aku i ka helu kelepona 1-888-982-3862 . Kākī ‘ole ia kēia kōkua nei. (Hawaiian)

Yog xav tau kev pab txhais lus Hmoob hau dauv tau rau 1-888-982-3862 . (Hmong)

Maka enyemaka asu su na Igbo kpoọ 1-888-982-3862 na akwughi ugwọ ọ bula (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, puo’ chiamare gratuitamente 1-888-982-3862 . (Italian)

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。 (Japanese)
Fii yo on hebu balal e ko yowittii e haala Pular noddee e oo numero doo 1-888-982-3862. Njodi woi fawaalii on. (Sudanic-Fulfulde)

Ukhitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo. (Swahili)

(Assyrian-Syrac) 1-888-982-3862

(Thai) 1-888-982-3862

(Telugu) 1-888-982-3862

(Tungan) 1-888-982-3862

(Turkese-Chuukese) 1-888-982-3862

(Turkish) 1-888-982-3862

(Ukrainian) 1-888-982-3862

(Vietnamese) 1-888-982-3862

(Yiddish) 1-888-982-3862

(Yoruba) 1-888-982-3862
Schedule of Benefits

Employer: State of Ohio
MSA: 285507
Issue Date: July 1, 2017
Effective Date: June 29, 2017
Schedule: 1A
Booklet Base: 1

For: Aetna Choice POS II

Aetna Choice POS II Medical Plan

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year Deductible*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible*</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Family Deductible*</td>
<td>$500</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

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

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

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:
- For **network** expenses: $1,500.
- For **out-of-network** expenses: $3,000.

Family Maximum Out of Pocket Limit:
- For **network** expenses: $3,000.
- For **out-of-network** expenses: $6,000.

**Lifetime Maximum Benefit per person**
- Unlimited
- Unlimited

*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.*

*All Covered Expenses Are Subject To The Plan Year Deductible Unless Otherwise Noted In The Schedule Below.*
Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Physical Exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons through age 21:</strong></td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons ages 22 but less than 40:</strong></td>
<td>100% per visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covered Persons age 40 and over:</strong></td>
<td>100% per visit</td>
<td>$30 visit copay then the plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td>No Plan Year deductible applies.</td>
</tr>
</tbody>
</table>

**Covered Persons through age 21:**

**Maximum Age & Visit Limits**

Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.

For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.

**Covered Persons ages 22 but less than 40:**

**Maximum Visits per Plan Year**

1 visit

No Covered

**Covered Persons age 40 and over:**

**Maximum Visits per Plan Year**

1 visit

1 visit
### Preventive Care Immunizations

Performed in a facility or physician's office

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage</th>
<th>Copay/Deductible</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.

### Screening & Counseling Services

Office Visits

- Obesity and/or Healthy Diet
- Sexually Transmitted Infections
- Genetic Risk for Breast and Ovarian Cancer

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Percentage</th>
<th>Copay/Deductible</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>60% per visits after Plan Year deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Obesity and/or Healthy Diet

Maximum Visits per Plan Year

(This maximum applies only to Covered Persons ages 22 & older.)

- 26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*

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

### Use of Tobacco Products

Maximum Visits per Plan Year

- unlimited visits*

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

### Sexually Transmitted Infections Benefit Maximums

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Maximum Visits per Plan Year</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 visits*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.
<table>
<thead>
<tr>
<th><strong>Well Woman Preventive Visits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
</tr>
<tr>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations</td>
</tr>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No Plan Year <strong>deductible</strong> applies.</td>
</tr>
<tr>
<td>60% per visit after Plan Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Well Woman Preventive Visits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Visits per Plan Year</strong></td>
</tr>
<tr>
<td>1 visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Exam</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Persons through age 21</strong></td>
</tr>
<tr>
<td>100% per exam</td>
</tr>
<tr>
<td>No Plan Year <strong>deductible</strong> applies.</td>
</tr>
<tr>
<td><strong>$30 copay</strong> per visit after the Plan Year <strong>deductible</strong> then the plan pays 60%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing Exam</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Persons age 21 and over</strong></td>
</tr>
<tr>
<td>80% per exam after Plan Year <strong>deductible</strong></td>
</tr>
<tr>
<td>60% per exam after Plan Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

| Hearing Aid Maximum per Plan Year for accident, congenital illness or injury |
| 80% after Plan Year **deductible** |
| 60% after Plan Year **deductible** |

| Hearing Aid Maximum per Lifetime for natural hearing loss |
| 50% after Plan Year **deductible** up to $1,000 lifetime maximum. |
| 50% after Plan Year **deductible** up to $1,000 lifetime maximum. |

<table>
<thead>
<tr>
<th><strong>Routine Cancer Screening</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient</strong></td>
</tr>
<tr>
<td>100% per visit</td>
</tr>
<tr>
<td>No Plan Year <strong>deductible</strong> applies.</td>
</tr>
<tr>
<td>60% per visit after Plan Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Maximums</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject to any age; family history and frequency guidelines as set forth in the most current:</td>
</tr>
<tr>
<td>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
</tr>
<tr>
<td>• the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td><strong>For details, contact your physician or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</strong></td>
</tr>
<tr>
<td>Subject to any age; family history and frequency guidelines as set forth in the most current:</td>
</tr>
<tr>
<td>• evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
</tr>
<tr>
<td>• the comprehensive guidelines supported by the Health Resources and Services Administration.</td>
</tr>
<tr>
<td><strong>For details, contact your physician or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lung Cancer Screening Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>One screening every 12 months*</td>
</tr>
<tr>
<td>One screening every 12 months*</td>
</tr>
</tbody>
</table>
**Important Note:** Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

<table>
<thead>
<tr>
<th><strong>Prenatal Care</strong></th>
<th>100% per visit</th>
<th>60% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Comprehensive Lactation Support and Counseling Services</strong></th>
<th>100% per visit</th>
<th>60% per visit after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lactation Counseling Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility or Office Visits</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Breast Pumps &amp; Supplies</strong></th>
<th>100% per item</th>
<th>60% per item after Plan Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Female Contraceptive Counseling Services - Office Visits**
- 100% per visit.
- No copay or deductible applies.
- $30 visit copay then the plan pays 100%
- No Plan Year deductible applies.

**Contraceptive Counseling Services - Maximum Visits either in a group or individual setting**
- 2* visits per 12 months
- Not Applicable

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

### Family Planning Services - Female Contraceptives

**Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.**
- 100% per item.
- No copay or deductible applies.
- $30 visit copay then the plan pays 100%
- No Plan Year deductible applies.

### Family Planning - Other

**Voluntary Sterilization for Males**

<table>
<thead>
<tr>
<th>Location</th>
<th>Coverage</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>100% per visit</td>
<td>No deductible</td>
</tr>
</tbody>
</table>

**Voluntary Sterilization for Females**

<table>
<thead>
<tr>
<th>Location</th>
<th>Coverage</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Vision Care

**Eye Examinations including refraction**

<table>
<thead>
<tr>
<th>Location</th>
<th>Coverage</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Persons through age 21:</td>
<td>100% per exam</td>
<td>No Plan Year deductible applies.</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits to Primary Care Physician</td>
<td>$20 visit copay then the plan pays 100%</td>
<td>$30 visit copay then the plan pays 100%</td>
</tr>
<tr>
<td>Office visits (non-surgical) to non-specialist</td>
<td>No Plan Year deductible applies.</td>
<td>No Plan Year deductible applies.</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Lab in a Physician's Office</td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Specialist Office Visits and Consultations only</td>
<td>$25 visit copay then the plan pays 100%</td>
<td>$30 visit copay then the plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>No Plan Year deductible applies.</td>
<td>No Plan Year deductible applies.</td>
</tr>
<tr>
<td>All other services performed in the office whether or not billed with an office visit</td>
<td>80% per procedure after Plan Year deductible</td>
<td>60% per procedure after Plan Year deductible</td>
</tr>
<tr>
<td>Physician Office Visits-Surgery</td>
<td>$20 visit copay then the plan pays 100%</td>
<td>$30 visit copay then the plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>No Plan Year deductible applies.</td>
<td>No Plan Year deductible applies.</td>
</tr>
<tr>
<td>Diagnostic X-Ray &amp; Lab in a Physician's Office</td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For details, contact your physician, log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call 1-800-949-3104.</td>
<td></td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Tobacco Use</td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of Benefits for maximums that may apply to these types of services</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of Benefits for maximums that may apply to these types of services</td>
</tr>
<tr>
<td>Individual Screening and Counseling Services for Obesity</td>
<td>100% per visit</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td></td>
<td>No copay or deductible applies.</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per visit - Individual Screening and Counseling</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of</td>
<td>Refer to the Preventive Care Benefit section earlier in this Schedule of</td>
</tr>
<tr>
<td>Services for Obesity</td>
<td>Benefits for maximums that may apply to these types of services</td>
<td>Benefits for maximums that may apply to these types of services</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>

*Important Note:*
Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

<table>
<thead>
<tr>
<th>All Other Services</th>
<th>$20 visit <strong>copay</strong> then the plan pays 100%</th>
<th>$30 per visit <strong>copay</strong> then the plan pays 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Plan Year <strong>deductible</strong> applies.</td>
<td>No Plan Year <strong>deductible</strong> applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services for Inpatient Facility and Hospital Visits</th>
<th>80% per visit after Plan Year <strong>deductible</strong></th>
<th>60% per visit after Plan Year <strong>deductible</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Administration of Anesthesia</th>
<th>80% per procedure after Plan Year <strong>deductible</strong></th>
<th>60% per procedure after Plan Year <strong>deductible</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Allergy Injections</th>
<th>80% per visit after Plan Year <strong>deductible</strong></th>
<th>60% per visit after Plan Year <strong>deductible</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Immunizations (that are not considered Preventive Care)</th>
<th>80% per visit after Plan Year <strong>deductible</strong></th>
<th>60% per visit after Plan Year <strong>deductible</strong></th>
</tr>
</thead>
</table>

### PLAN FEATURES

<table>
<thead>
<tr>
<th>Emergency Medical Services</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Emergency Facility and Physician</strong></td>
<td>$100 <strong>copay</strong> per visit after the Plan Year <strong>deductible</strong> then the plan pays 80% (the copay is waived if you are admitted)</td>
<td>Paid the same as the Network level of benefits.</td>
</tr>
<tr>
<td>See Important Note Below</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Non-Emergency Care in a Hospital Emergency Room</th>
<th>$100 <strong>copay</strong> per visit after the Plan Year <strong>deductible</strong> then the plan pays 80%</th>
<th>$100 <strong>copay</strong> per visit after the Plan Year <strong>deductible</strong> then the plan pays 60%</th>
</tr>
</thead>
</table>
**Important Notice:**
A separate hospital emergency room copay applies for each visit to an emergency room for emergency care. If you are admitted to a hospital as an inpatient immediately following a visit to an emergency room, your copay is waived.

Covered expenses that are applied to the emergency room copay cannot be applied to any other copay under your plan. Likewise, covered expenses that are applied to any of your plan’s other copays cannot be applied to the emergency room copay.

---

### Urgent Care Services

<table>
<thead>
<tr>
<th><strong>Urgent Medical Care</strong>&lt;br&gt;(at a non-hospital free standing facility)</th>
<th>$30 per visit copay then the plan pays 100%</th>
<th>$35 per visit copay then the plan pays 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Urgent Use of Urgent Care Provider</strong>&lt;br&gt;(at an Emergency Room or a non-hospital free standing facility)</td>
<td>$30 per visit copay then the plan pays 100%</td>
<td>$35 per visit copay then the plan pays 60%</td>
</tr>
</tbody>
</table>

**Important Notice:**
A separate urgent care copay applies for each visit to an urgent care provider for urgent care.

Covered expenses that are applied to the urgent care copay cannot be applied to any other copay under your plan. Likewise, covered expenses that are applied to your plan’s other copays cannot be applied to the urgent care copay.

---

### PLAN FEATURES

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Diagnostic and Preoperative Testing</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Complex Imaging Services

| **Complex Imaging** | 80% per test after Plan Year deductible | 60% per test after Plan Year deductible |

#### Diagnostic Laboratory Testing

| **Diagnostic Laboratory Testing** | 80% per procedure after Plan Year deductible | 60% per procedure after Plan Year deductible |
### Diagnostic X-Rays (except Complex Imaging Services)

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic X-Rays</td>
<td>80% per procedure after Plan Year deductible</td>
<td>60% per procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Outpatient Surgery

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>80% per visit/surgical procedure after Plan Year deductible</td>
<td>60% per visit/surgical procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Outpatient Surgery

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>80% per visit/surgical procedure after Plan Year deductible</td>
<td>60% per visit/surgical procedure after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Inpatient Facility Expenses

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birthing Center</td>
<td>80% per admission after Plan Year deductible</td>
<td>60% per admission after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Hospital Facility Expenses

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>80% per admission after Plan Year deductible</td>
<td>60% per admission after Plan Year deductible</td>
</tr>
<tr>
<td>Other than Room and Board</td>
<td>80% per admission after Plan Year deductible</td>
<td>60% per admission after Plan Year deductible</td>
</tr>
</tbody>
</table>

### Skilled Nursing Inpatient Facility

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 180 days per admission</td>
<td>80% per admission</td>
<td>80% per admission</td>
</tr>
<tr>
<td></td>
<td>No Plan Year deductible applies</td>
<td>No Plan Year deductible applies</td>
</tr>
<tr>
<td>After 180 days per admission</td>
<td>60% per admission</td>
<td>60% per admission</td>
</tr>
<tr>
<td></td>
<td>No Plan Year deductible applies</td>
<td>No Plan Year deductible applies</td>
</tr>
</tbody>
</table>

### Specialty Benefits

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care (Outpatient)</td>
<td>80% per visit after the Plan Year deductible</td>
<td>60% per visit after the Plan Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Visits per Plan Year</td>
<td>180 visits</td>
<td>180 visits</td>
</tr>
</tbody>
</table>

### Skilled Nursing Care (Outpatient)

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Care (Outpatient)</td>
<td>80% per visit after the Plan Year deductible</td>
<td>60% per visit after the Plan Year deductible</td>
</tr>
</tbody>
</table>

### Private Duty Nursing (Outpatient)

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Duty Nursing (Outpatient)</td>
<td>80% per visit after the Plan Year deductible</td>
<td>60% per visit after the Plan Year deductible</td>
</tr>
</tbody>
</table>
### Hospice Benefits

<table>
<thead>
<tr>
<th>Description</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice Care - Facility Expenses (Room &amp; Board)</strong></td>
<td>100% per admission</td>
<td>100% per admission</td>
</tr>
<tr>
<td></td>
<td>No Plan Year <strong>deductible</strong> applies</td>
<td>No Plan Year <strong>deductible</strong> applies</td>
</tr>
<tr>
<td><strong>Hospice Care - Other Expenses during a stay</strong></td>
<td>100% per admission</td>
<td>100% per admission</td>
</tr>
<tr>
<td></td>
<td>No Plan Year <strong>deductible</strong> applies</td>
<td>No Plan Year <strong>deductible</strong> applies</td>
</tr>
<tr>
<td>Maximum Benefit per lifetime</td>
<td>Unlimited days</td>
<td>Unlimited days</td>
</tr>
</tbody>
</table>

### Hospice Outpatient Visits

<table>
<thead>
<tr>
<th>Description</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% per visit</td>
<td>100% per visit</td>
<td></td>
</tr>
<tr>
<td>No Plan Year <strong>deductible</strong> applies</td>
<td>No Plan Year <strong>deductible</strong> applies</td>
<td></td>
</tr>
</tbody>
</table>

### PLAN FEATURES

#### Infertility Treatment

<table>
<thead>
<tr>
<th>Description</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Infertility Expenses</strong></td>
<td>80% per visit after the Plan Year <strong>deductible</strong></td>
<td>60% per visit after the Plan Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Obesity Treatment Non Surgical

<table>
<thead>
<tr>
<th>Description</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Obesity Treatment (non surgical)</strong></td>
<td>80% per visit after the Plan Year <strong>deductible</strong></td>
<td>60% per visit after the Plan Year <strong>deductible</strong></td>
</tr>
</tbody>
</table>

#### Obesity Treatment Surgical

<table>
<thead>
<tr>
<th>Description</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Morbid Obesity Surgery (includes Surgical procedure, bariatric surgery and Acute Hospital Services)</strong></td>
<td>80% per admission after Plan Year <strong>deductible</strong></td>
<td>60% per admission after Plan Year <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Outpatient Morbid Obesity Surgery (including the physician office visit, related outpatient services)</strong></td>
<td>80% per service after Plan Year <strong>deductible</strong></td>
<td>60% per service after Plan Year <strong>deductible</strong></td>
</tr>
<tr>
<td>Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
### PLAN FEATURES

<table>
<thead>
<tr>
<th>Networking Type</th>
<th>Network (IOE Facility)</th>
<th>Network (Non-IOE Facility)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplant Services Facility and Non-Facility Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant Facility Expenses</strong></td>
<td>80% per admission after Plan Year, deductible</td>
<td>80% per admission after Plan Year, deductible</td>
<td>60% per admission after Plan Year, deductible</td>
</tr>
<tr>
<td><strong>Transplant Physician Services</strong> (including office visits)</td>
<td>80% per visit after the Plan Year, deductible</td>
<td>80% per visit after the Plan Year, deductible</td>
<td>60% per visit after the Plan Year, deductible</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

**Other Covered Health Expenses**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ground, Air or Water Ambulance</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>No Plan Year deductible applies.</td>
<td>No Plan Year deductible applies.</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

**Autism Spectrum Disorder**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy, Occupational Therapy, Speech Therapy</td>
<td>80% per visit after Plan Year deductible.</td>
<td>60% per visit after Plan Year deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Equipment, Supplies and Education</td>
<td>80% per item after the Plan Year deductible</td>
<td>60% per item after the Plan Year deductible</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

**Durable Medical and Surgical Equipment**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trial Therapies (Experimental or Investigational Treatment)</td>
<td>80% per visit after Plan Year deductible.</td>
<td>60% per visit after Plan Year deductible.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Patient Costs</td>
<td>80% per visit after Plan Year deductible.</td>
<td>60% per visit after Plan Year deductible.</td>
</tr>
</tbody>
</table>

### PLAN FEATURES

**Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic Devices</td>
<td>80% per item after Plan Year deductible</td>
<td>60% per item after Plan Year deductible</td>
</tr>
<tr>
<td>PLAN FEATURES</td>
<td>NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Outpatient Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Chemotherapy</em></td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td><em>Infusion Therapy</em></td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td><em>Radiation Therapy</em></td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short Term Outpatient Rehabilitation Therapies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Outpatient Physical and Occupational Therapy only</em></td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
<tr>
<td><em>Speech Therapy only</em></td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN FEATURES</th>
<th>NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spinal Manipulation (Chiropractic Treatment)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Requires review for medical necessity after the 25th visit.</td>
<td>80% per visit after Plan Year deductible</td>
<td>60% per visit after Plan Year deductible</td>
</tr>
</tbody>
</table>
Expense Provisions

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

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the out-of-network provider deductibles will be applied to satisfy the network provider deductibles. Covered expenses applied to the network provider deductibles will be applied to satisfy the out-of-network provider deductibles.

All covered expenses accumulate toward the network provider and out-of-network provider deductibles except for those covered expenses identified later in this Schedule of Benefits.

You and each of your covered dependents have separate Plan Year deductibles. Each of you must meet your deductible separately and they cannot be combined. This Plan has individual and family Plan Year deductibles.

Network Provider Plan Year Deductible

Individual
This is the amount of covered expenses that you and each of your covered dependents incur each Plan Year from a network provider for which no benefits will be paid. This individual Plan Year deductible applies separately to you and each of your covered dependents. After covered expenses reach this individual Plan Year deductible, this Plan will begin to pay benefits for covered expenses that you incur from a network provider for the rest of the Plan Year.

Family Deductible Limit
When you and each of your covered dependents incur covered expenses that apply towards the individual Plan Year deductibles, these expenses will also count toward a family deductible limit.

To satisfy this family deductible limit for the rest of the Plan Year, the following must happen:

The combined covered expenses that you and each of your covered dependents incur towards the individual Plan Year deductibles must reach this family deductible limit in a Plan Year.

When this occurs in a Plan Year, the individual Plan Year deductibles for you and your covered dependents will be considered to be met for the rest of the Plan Year.

Out-of-Network Provider Plan Year Deductible

Individual
This is the amount of covered expenses that you and each of your covered dependents incur each Plan Year from an out-of-network provider for which no benefits will be paid. This individual Plan Year deductible applies separately to you and each of your covered dependents. After covered expenses reach this individual Plan Year deductible; this Plan will begin to pay benefits for covered expenses that you incur from an out-of-network provider for the rest of the Plan Year.
Family Deductible Limit
When you and each of your covered dependents incur covered expenses that apply towards the individual Plan Year deductibles, these expenses will also count toward a family deductible limit.

To satisfy this family deductible limit for the rest of the Plan Year, the following must happen:

The combined covered expenses that you and each of your covered dependents incur towards the individual Plan Year deductibles must reach this family deductible limit in a Plan Year.

When this occurs in a Plan Year, the individual Plan Year deductibles for you and your covered dependents will be considered to be met for the rest of the Plan Year.

Copayments and Benefit Deductible Provisions

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

Payment Provisions

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

Maximum Out-of-Pocket Limit
The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for covered expenses during the Plan Year. This Plan has an individual Maximum Out-of-Pocket Limit. As to the individual Maximum Out-of-Pocket Limit, each of you must meet your Maximum Out-of-Pocket Limit separately and they cannot be combined and applied towards one limit.

Certain covered expenses do not apply toward the Maximum Out-of-Pocket Limit. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible network provider expenses you or your covered dependents have paid during the Plan Year meets the individual Maximum Out-of-Pocket Limit, this Plan will pay 100% of such covered expenses that apply toward the limit for the remainder of the Plan Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur covered expenses that apply towards the individual Plan Year network provider Maximum Out-of-Pocket Limit, these expenses will also count toward a family network provider Maximum Out-of-Pocket Limit.
To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Plan Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Plan Year.

**Out-of Network Provider Maximum Out-of-Pocket Limit**

**Individual**

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Plan Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Plan Year for that person.

**Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Plan Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Plan Year.

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

**Expenses That Do Not Apply to Your Out-of-Pocket Limit**

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from Aetna.

**Precertification Benefit Reduction**

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

Failure to precertify an inpatient hospital stay when required will result in a benefits reduction as follows:

- A $350 penalty will be applied.

**General**

Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.