

Effective March 1, 2009

Harris County

Plan



Document

Commissioners Court

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Produced by: Harris County Office of Human
Resources & Risk Management

BASE PLUS PLAN 100/70

Group Plan of Benefits For: Harris County

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") or any of its affiliates but will be paid from the Employer's funds. Aetna and its HMO affiliates will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer:

Employers: Harris County, the Harris County Flood Control District, and other political subdivisions and agencies to whose employees the Harris County Commissioners Court agrees to provide coverage under the Plan or to whom the Harris County Commissioners Court is required by law to provide coverage under the Plan.

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Summary of Coverage

The benefits shown in this booklet are available for you and your eligible dependents.

For out of the country services, call Aetna.

This is an electronic version of the Summary of Coverage on file with your Employer and Aetna Life Insurance Company, Hartford, CT. In case of a discrepancy between this electronic version and the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth by such group insurance contract will prevail. To obtain a printed copy of this Summary of Coverage, please contact your Employer.

Eligibility

Employees

You are in an Eligible Class if you are a regular full-time officer or employee working at least 32 hours per week and your Employer has determined that your place of residence is within the Service Area covered under this Plan.

Your Eligibility Date, if you are then in an Eligible Class, is the Effective Date of this Plan. Otherwise, it is the first day of the calendar month coinciding with or next following the date you complete a probationary period of 90 days of continuous service for your Employer or, if later, the date you enter the Eligible Class.

You can remain in an Eligible Class as a retired employee if you retire under your Employer's IRS Qualified Retirement Plan and will receive a pension, except a deferred vested pension. You may continue your Health Expense Coverage and any coverage you have for your dependents.

If you retired before the Effective Date of this Plan, you are also in an Eligible Class. You must follow the Enrollment Procedure. You may have Health Expense Coverage for you and your dependents.

Dependents

"Dependent" or "Eligible Dependent" of an Employee or retired employee who is a member of an Eligible Class includes that person's:

- legal spouse;
- unmarried children over eighteen* (18) must be enrolled as a full-time student in an accredited college, university or trade school. For purposes of determining eligibility, an Employee's "children" includes:
 - natural children;
 - legally adopted children (including children placed with adoptive parents pending finalization of adoption proceedings);
 - stepchildren who permanently reside in the employee's home;
 - children over age 24 who remain dependent on the Employee or retired employee for support and maintenance because the child becomes incapable of self support due to mental or physical incapacity. The incapacity must have commenced prior to reaching age 25 under the Plan or a prior health Plan of the Customer (if the child was insured on the date of termination of the prior health Plan);
 - unmarried grandchildren under age 25 for whom the Employee or retired employee furnishes (a) a certificate of financial dependency, (b) birth certificate on the grandchild, (c) birth certificate on the grandchild's mother or father indicating that the Employee is the biological or adoptive parent and (d) the grandchild is claimed as a dependent on your Federal Income Tax Return;
 - children under age 19 permanently residing in the Employee's or retired employee's home and for whom the Employee or retired employee is the appointed permanent legal guardian or permanent legal custodian; and
 - foster children under age 19 for whom the Employee or retired employee furnishes documents from the State of Texas

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- All other individuals to whom the Customer is required by law to extend the coverage provided in the Plan shall also be considered Dependents to the extent they do not also qualify for coverage as Employees; and
 - All former Employees' Dependents to the extent that the Customer provides for such coverage by Resolution of the Commissioners Court shall also be considered Dependents to the extent they do not also qualify for coverage as Employees.

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

*For dependents reaching age 25, coverage continues until the end of the calendar month in which the dependent child turns age 25.

Enrollment Procedure

Initial Enrollment

You will be required to enroll in a manner determined by your Employer. This will allow your Employer to deduct your contributions from your pay. Be sure to enroll within the same calendar year of the qualifying event. Your contributions toward the cost of this coverage will be deducted from your pay and are subject to change. The rate of any required contributions will be determined by your Employer. See your Employer for details.

Late Enrollment

A "Late Enrollee" is a person (including yourself) for whom you do not elect Health Expense Coverage within the time same calendar year of the qualifying event.

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

You must enroll within the time period prescribed by your Employer before the end of the next annual late entrant enrollment period established by your Employer.

Coverage for a Late Enrollees will become effective on the "coverage begin date" set by the county auditor.

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

Special Enrollment Periods

A person, including yourself, will not be considered to be a **Late Enrollee** if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
 - i. the person was covered under another group health plan or other health insurance coverage; and
 - ii. you stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if your Employer requires the statement and gives you notice of the requirement; and

the person loses such coverage because:

- i. it was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
- ii. it was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
 - legal separation or divorce;
 - death;

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- termination of employment;
 - reduction in the number of hours of employment;
 - the employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
 - cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - the operation of another Plan's lifetime maximum on all benefits, if applicable; or

iii. employer contributions toward the coverage were terminated.

- You elect coverage within the same calendar year of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be **Late Enrollees** if your Employer offers multiple health benefit plans and you elect a different plan during the open enrollment period established by your Employer.

Also, the following persons will not be considered to be **Late Enrollees** given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within the same calendar year of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within the same calendar year of the court order.

Coverage will be effective on the date determined by your Employer:

- i. in the case of marriage, on the date the completed request for enrollment is received;
- ii. in the case of a newborn, on the date of birth;
- iii. in the case of adoption, on the date of the child's adoption or placement for adoption;
- iv. in the case of court ordered coverage of a spouse or child, on the date of the court order;
- v. in the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
- vi. in the case of loss of coverage for other reasons, the date on which the applicable event occurred.

Effective Date of Coverage

Employees

Your coverage will take effect on your Eligibility Date as determined by your Employer.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if, by then, you have enrolled for dependent coverage. You should report any new dependents. This may affect your contributions. If you do not do so within the same calendar year of the qualifying event, coverage will take effect as provided in the Late Enrollee section of this Summary of Coverage.

Note: This Plan will pay a benefit for Covered Medical Expenses incurred by a newborn child during the first 31 days of life, whether or not the child is or becomes enrolled under the Plan.

If the child does not become enrolled under the Plan, coverage will terminate at the end of such 31 day period. Any Extension of Benefits provision will apply. The Continuation of Coverage under Federal Law provision will not apply.

Special Rules Which Apply to an Adopted Child

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within the same calendar year of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption if the written request to enroll the child is within 31 days the child is "placed for adoption." If request is not made within 31 days of the qualifying event, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due To A Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to effect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order issued on or after the date your coverage becomes effective. You must make written request for such coverage. Coverage for the child will become effective on the date specified by your Employer.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Health Expense Coverage

Employees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Note: As described in the definition of “recognized charge” in the Glossary, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate payable in certain circumstances for a service or supply.

Prescription Drug Expense Coverage

Payment Percentage

100% as to:

Preferred Pharmacy - Retail

Copay per Prescription or Refill

Generic Drugs	25% copay, with \$5 minimum and \$20 maximum, per prescription or refill for a 30 day supply
Brand Name Drugs	25% copay, with \$20 minimum and \$75 maximum, per prescription or refill for a 30 day supply

Preferred Pharmacy - Mail Order

Generic Drugs	25% copay, with \$10 minimum and \$40 maximum, for each supply of up to 90 days per prescription or refill
Brand Name Drugs	25% copay, with \$40 minimum and \$150 maximum, for each supply of up to 90 days per prescription or refill

80% as to:

Drugs and Medicines dispensed by a Non-Preferred Pharmacy

Mandatory Specialty Prescriptions

The Copay for the initial two prescription fills or refills of a specialty drug or a **self-injectable drug** and blood clotting factor is:

25% of the negotiated charge between Aetna and the **preferred pharmacy** vendor or supplier designated by Aetna, \$25 minimum and \$100 maximum.

Deductible and Copay Amounts

Calendar Year Deductible \$600

This Calendar Year Deductible applies to all expenses incurred for Non-Preferred Care and for care for dependents who permanently reside outside the Service Area covered under this Plan.

Family Deductible Limit \$1,800

Emergency Room Deductible/Copay \$150 per visit

This Emergency Room Deductible/Copay applies to Hospital Expenses incurred for emergency care provided by a Preferred or Non-Preferred Care Provider and for care of dependents who permanently reside outside the Service Area covered under this Plan. This amount is waived if a person becomes confined in a hospital.

Outpatient Surgical Facility Copay \$250 per visit

The Outpatient Surgical Facility Copay applies to all outpatient surgery performed in the outpatient department of a **Hospital** or Ambulatory Surgical Center. The Outpatient Surgical Facility Copay applies to Preferred Care.

Urgent Care Copay \$40 per visit

This Urgent Care Copay applies to expenses incurred for urgent care provided by a Preferred Care Provider.

Inpatient Hospital Copay \$400

This Inpatient Hospital Copay applies to Inpatient Hospital Expenses incurred for Preferred Care.

Outpatient Hospital Copay \$250

This Outpatient Hospital Copay applies to Outpatient Hospital Expenses incurred for Preferred Care.

The Benefits Payable

After any applicable deductible or copay amount, the Health Expense Benefits paid under this Plan in a calendar year are paid at the Payment Percentage which applies to the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet.

If any expense is covered under one type of Covered Medical expense, it cannot be covered under any other type.

The **Recognized Charge** as explained in the Glossary applies to both **Preferred Care** and **Non-preferred Care**.

Payment Percentage

The Payment Percentage applies after any deductible or copay amounts.

<i>Hospital Expenses</i>	Preferred Care	Non-Preferred Care
Worldwide Emergency Care/Treatment	100% after a \$150 copay. If admitted, copay waived and paid at 100% after \$400 copay	100% after a \$150 copay. If admitted, copay waived and paid at 100% after \$400 copay
Non-Emergency Care/ Treatment	No Coverage	No Coverage
Urgent Care	100% after a \$40 copay	70% after CYD*
Non-Urgent Care	No Coverage	No Coverage
Hospital Expenses - Inpatient	100% after a \$400 copay	70% after CYD
Hospital Expenses - Outpatient	100% after a \$250 copay	70% after CYD

*CYD - Calendar Year Deductible

Payment Percentage (Continued)

<i>Alternative to Physician Office Visit</i>	Preferred Care	Non-Preferred Care
<i>Walk-in Clinic Non-Emergency Visit</i>	100% after a \$20 copay	70% after CYD

<i>Physician Fees**</i>		
Non-Surgical Office Visit	100% after a \$20 copay	70% after CYD
Routine Physical Exam Expenses/Immunizations	100% after a \$20 copay	70% after CYD
Routine Hearing Exam Expenses	100% after a \$20 copay	70% after CYD
Hearing Aids	80%	80% after CYD
Allergy Injections	100%	70% after CYD
Routine Gynecological Exam (including Pap Smear)	100% after a \$20 copay	70% after CYD
Other Physician Services	100%	70% after CYD

<i>Specialist Fees</i>		
Specialist Office Care	100% after a \$30 copay	70% after CYD*
Routine Hearing Exam Expenses	100% after a \$30 copay	70% after CYD
Allergy Test/Treatment	100% after a \$30 copay	70% after CYD
Routine Gynecological Exam (including Pap Smear)	100% after a \$30 copay	70% after CYD
Other Physician Services	100%	70% after CYD

<i>Covered Medical Expenses</i>	Preferred Care	Non-Preferred Care
Mammogram Age 35-39/ 1 Baseline Age 40 and over/ 1 each year	100%	70% after CYD
Outpatient Surgical Expenses	100% after \$250 copay	70% after CYD
Colonoscopy	100%	70% after CYD
Short-Term Rehabilitation Expenses	100% after a \$20 Copay	70% after CYD
Spinal Manipulation Treatment Expenses	100% after a \$30 Copay	70% after CYD
Ambulance	100%	100%
Diagnostic X-ray and Lab	100%	70% after CYD
Durable Medical Equipment	100%	70% after CYD

*CYD - Calendar Year Deductible

**Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury.

Payment Percentage (Continued)

Covered Medical Expenses	Preferred Care	Non-Preferred Care
Convalescent Facility Expenses/Skilled Nursing Care Expenses	100% after CYD	70% after CYD
Home Health Care Expenses	100% after CYD	70% after CYD
Private Duty Nursing - Outpatient	100% after CYD	50% after CYD
Hospice Care Expenses Inpatient Care Outpatient Care	100% 100% up to maximums shown on page 13	100% 100% up to maximums shown on page 13
Acupuncture Outpatient	100%	100%
Morbid Obesity (Bariatric Surgery) - Inpatient	100% after a \$400 Copay	Not Covered
Morbid Obesity (Bariatric Surgery) - Outpatient	100% after a \$250 Copay	Not Covered
Complex Imaging Services (High Tech Radiology)	100%	70% after CYD
National Medical Excellence Travel and Lodging Expenses	100% up to maximums shown on page 13	100% up to maximums shown on page 13
All Other Covered Medical Expenses for which a Payment Percentage is not otherwise shown	100%	70% after CYD

Basic Infertility Expenses		
Calendar Year Deductible Applies	No	Yes
Payment Percentage for Artificial Insemination or Ovulation induction	50%	50% after CYD
Diagnosis and treatment of the underlying medical condition	100%	70% after CYD

Mental Disorders Expenses	Preferred Care	Non-Preferred Care
Inpatient Treatment	100% after \$400 copay	70% after CYD
Outpatient Treatment	100% after a \$30 copay	70% after CYD
Outpatient Calendar Year Maximum Visits	60 visits	70% after CYD

Hospice Care	
Maximum Number of Days	30
Outpatient Maximum	\$5,000
Short-Term Rehabilitation	
Maximum Visits	60 per calendar year
Spinal Manipulation Maximum	\$600 per calendar year
Benefit	
Hearing Aids	1 pair in 36 months in a row, up to a maximum of \$1,500
National Medical Excellence	
Lodging Expenses Maximum	\$50 per day
Travel and Lodging Maximum	\$10,000
Private Room Limit	The institution's semiprivate rate.

Maximums are a combined limit for preferred and non-preferred care.

Lifetime Maximum Benefit:

Preferred Lifetime Maximum - There is no Lifetime Maximum Benefit (overall limit) that applies to the Special Comprehensive Medical benefits described in the Booklet. The only maximum benefit limits are those specifically mentioned in your Booklet.

Non-Preferred Lifetime Maximum - \$1,000,000

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female employees and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.
- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID Card.

The expenses must be incurred while the person is covered under this Plan. If expenses are incurred after the coverage ceases, no benefits will be paid.

Elective abortions: Coverage is limited to abortions performed because the life of the mother would be in danger if the fetus were carried to term and those which result in medical complications.

Prior Plans: Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Health Expense Coverage: Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted as provided elsewhere in the plan document on file with your Employer. Any increase is subject to any Active Work Rule described in Effective Date of Coverage section of this Summary of Coverage.

Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General

This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Your Health Benefits

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Your Primary Care Physician

Although you are not required to select a Primary Care Physician, you are encouraged to do so. Consult your Primary Care Physician whenever you have questions about your health. He or she provides basic and routine care, and can refer you to specialists and facilities in the network, when medically necessary.

Primary and Preventive Care

Your Primary Care Physician can provide preventive care and treat you for illnesses and injuries. You are only subject to the Primary Care Physician copay when accessing care from your selected Primary Care Physician. Please note that care received from any other network physician is subject to the specialist copay.

Coverage for out-of-network primary and preventive care is limited. Refer to the “Summary of Coverage” for details.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by a **pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **pharmacy's** charge for the drug is more than the **copay per prescription** or refill.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by a **preferred pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the preferred pharmacy; and
- Aetna.

Any amount so determined will be paid to the **preferred pharmacy** on your behalf.

Mandatory Specialty Prescriptions - A benefit will be paid at the preferred level of coverage for an injectable **prescription drug** and blood clotting factor obtained from a **Preferred Pharmacy**, vendor, or supplier that Aetna designates to supply such **prescription drug**.

The initial two prescriptions for a **self-injectable drug** and blood clotting factor must be filled at a **preferred pharmacy**. After the second prescription, all refills of a **self-injectable drug** and blood clotting factor must be obtained through the Aetna's **specialty pharmacy network** or supplier that Aetna designates to supply such **prescription drug**.

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In figuring the benefit amount, a Separate Brand Name Fee applies to **brand name drugs** in addition to any applicable **copay**. The amount of the Separate Brand Name Fee will be equal to the difference between the cost of the **brand name drug** and the generic equivalent.

The Separate Brand Name Fee will apply to any **brand name drug** dispensed unless:

- there is no generic equivalent to the **brand name drug**; or
- the **pharmacy** is unable to supply the **generic drug** at the time the **prescription** is presented.

The Benefit Amount for each covered **prescription drug** or refill dispensed by a **non-preferred pharmacy** will be an amount equal to the Payment Percentage of the **non-preferred pharmacy's** charge for the drug

Limitations

No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 30 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 30 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:

fertility drugs;

allergy sera or extracts; and

Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug that is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:
 - if the **prescriber** has not specified the number of refills; or
 - if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.
- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any drugs which do not, by federal or state law, require a prescription order (i.e. an over-the-counter (OTC) drug), even if a prescription is written, other than diabetic supplies.
- Any **Prescription Drug** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength.
- For immunization agents.
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs.

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- For more than 6 unit doses per 30 day supply for the following drugs used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy:

sildenafil citrate;
phentolamine;
apomorphine;
alprostadil; or
any other **prescription drug** that

is in a similar or identical class,
has a similar or identical mode of action or exhibits similar or identical outcomes.

This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by Aetna based on the comparable cost for a 30 day supply of pills.

- For any drug dispensed by a **mail order pharmacy** for use for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
- For appetite suppressants.
- For more than a 90 day supply of any smoking cessation aids or drugs within a calendar year.
- For lost, stolen, misplaced or damaged prescriptions.
- For more than the quantity limits specified by Aetna.
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not a **preferred pharmacy**. However this Limitation will not apply if the Coordination of Benefits provision is applicable and Aetna is the secondary prescription drug plan.

Step Therapy Program

Currently Step Therapy/Certification is required for **Proton Pumps Inhibitor** under the Step Therapy Program:

- The use of one or more prerequisite therapy drugs is required prior to the time a Step Therapy drug is dispensed in order for a Step Therapy drug to be considered a Covered **Prescription Drug** Expense.
- No benefits will be payable for a Step Therapy drug unless:

the corresponding prerequisite therapy drug(s) are used first. However, if it is Necessary for you to be initially treated with a Step Therapy drug the **Prescriber** of the drug may request a medical exception by following the Certification Procedures section below.

Certification Procedures

It is your responsibility to arrange for the **prescriber** of the drug to call the number shown on your ID Card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug.

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Special Comprehensive Medical Coverage

Although a specific service may be listed as a covered expense, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of an illness or condition. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

For **Preferred Care**:

- If a private room is used, the daily **board and room** charge will be covered if:
 - the person's **Preferred Care Provider** requests the private room; and
 - the request is approved by Aetna.
- If the above procedures are not met, any part of the daily **board and room** charge which is more than the **semiprivate rate** is not covered.

For **Non-Preferred Care**:

Not included is any charge for daily **board and room** in a private room over the **semiprivate rate**.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Outpatient Surgical Facility Expenses

Charges made in its own behalf by:

- A **surgery center**; or
- The outpatient department of a **hospital**;

for Outpatient Services and Supplies furnished in connection with a surgical procedure performed in the center or in a **hospital**. The procedure must meet these tests:

- It is not expected to:
 - result in extensive blood loss;
 - require major or prolonged invasion of a body cavity; or
 - involve any major blood vessels.
- It can safely and adequately be performed only in a **surgery center** or in a **hospital**.
- It is not normally performed in the office of a **physician** or a **dentist**.

Outpatient Services and Supplies

These are services and supplies furnished by the center or by a **hospital** on the day of the procedure.

Limitations

No benefit is paid for charges incurred while the person is confined as a full-time inpatient in a **hospital**.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physician's** services.
- Medical Supplies.

Benefits will be paid for no longer than the Convalescent Days Maximum during any one plan year.

Limitations to Convalescent Facility Expenses

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses

Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are 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 aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:

medical supplies;

drugs and medicines prescribed by a **physician**; and

lab services provided by or for a **home health care agency**.

There is a maximum to the number of visits covered in a plan year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses

This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.

Alternatives to Physician Office Visit

Walk-in Clinic Visits

Covered expenses include charges made by walk-in clinics for: Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

You are responsible for any **copayment, coinsurance** or **deductible** listed on your Schedule of Benefits.

Routine Physical Exam Expenses

The charges for a routine physical exam given to you, your spouse, or your dependent child may be included as Covered Medical Expenses. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included are:

- X-rays, laboratory and other tests including a Pap Smear given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.

For a dependent child:

To qualify as a covered physical exam, the **physician's** exam must include at least:

- a review and written record of the patient's complete medical history;
- a check of all body systems; and
- a review and discussion of the exam results with the patient or with the parent or guardian.

For all exams given to your child under age 7, Covered Medical Expenses will not include charges for:

- More than 7 exams in the first year of the child's life.
- More than 2 exams in the second year of the child's life; or
- More than one exam per calendar year during the next 5 years of the child's life.

For all exams given to your child age 7 up to age 18, Covered Medical Expenses will not include charges for more than one exam per calendar year.

For all exams given to your child age 18 and over, Covered Medical Expenses will not include charges for more than one exam per calendar year.

For you and your spouse:

For all exams given to you or your spouse, Covered Medical Expenses will not include charges for more than one exam per calendar year.

Also included as Covered Medical Expenses are charges made by a physician for one annual routine gynecological exam. Included as part of the exam is a routine Pap smear.

Covered Medical Expenses also included charges incurred for a digital rectal exam and a prostate specific antigen (PSA) test for males age 40 or over for routine screening for cancer.

Not covered are charges for:

- services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer;
- services which are for diagnosis or treatment of a suspected or identified injury or disease;
- exams given while the person is confined in a **hospital** or other place for medical care;
- services not given by a **physician** or under his or her direction;
- medicines, drugs, appliances, equipment or supplies;
- psychiatric, psychological, personality or emotional testing or exams;
- exams in any way related to employment;
- premarital exams;
- vision, hearing or dental exams;
- a **physician's** office visit in connection with immunization or testing for tuberculosis.

Routine Hearing Exam Expenses

Covered Medical Expenses include charges for an audiometric exam. The services must be performed by:

a physician certified as an otolaryngologist or otologist; or
an audiologist who either:

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

who performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Covered Medical Expenses will not include charges for more than one hearing exam in 24 months in a row.

Not included are charges for:

- any ear or hearing exam to diagnose or treat a disease or injury;
- drugs or medicines;
- any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;
- any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- any hearing care service or supply which does not meet professionally accepted standards;
- any service or supply received while the person is not covered;
- any exams given while the person is confined in a **hospital** or other facility for medical care; or
- any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

Loss Or Impairment of Speech Or Hearing Expenses

This Plan pays for charges for the diagnosis or non-surgical treatment by a **physician** for loss or impairment of speech or hearing; but only if the charge is made for:

- Diagnostic services rendered to find out if and to what extent the person's ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a person's ability to speak or hear.
- Hearing aids, hearing aid evaluation tests, and hearing aid batteries.

Not covered are charges for:

- Diagnostic or rehabilitative services rendered before the person becomes eligible for coverage or after termination of coverage.
- Hearing exams required as a condition of employment.
- Special education for a person whose ability to speak or hear is lost or impaired. This includes lessons in sign language, speaking aids and training in the use of such aids.

Skilled Nursing Care Expenses

The charges made by a **R.N.** or **L.P.N.** or a nursing agency for "skilled nursing services" are included as Covered Medical Expenses. No other charges made by a **R.N.** or **L.P.N.** or a nursing agency are covered. As used here, "skilled nursing services" means these services:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R. N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate.

Benefits will not be paid during a plan year for private duty nursing for any shifts 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.

Not included as "skilled nursing services" is:

- that part or all of any nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs and companionship activities; or
- any private duty nursing care, given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows:

for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of:

change in patient medication;

need for treatment of an **emergency condition** by a **physician**, or the onset of symptoms indicating the likely need for such services;

surgery; or

release from inpatient confinement; or

- any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Hospice Care Expenses

Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**; or
- **convalescent facility**;

which are for:

Inpatient Care

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
 - pain control; and
 - other acute and chronic symptom management.
- Not included is any charge for daily board and room in a private room over the **semiprivate rate**. Also not included is the charge for any day of confinement in excess of the Maximum Number of Days for all confinements for **Hospice Care**.

Outpatient Care

- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses For Outpatient Care

Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.** for up to 8 hours in any one day.
- Medical social services under the direction of a **physician**. These include:

assessment of the person's:

social, emotional, and medical needs; and

the home and family situation;

identification of the community resources which are available to the person; and

assisting the person to obtain those resources needed to meet the person's assessed needs.

- Psychological and dietary counseling.

-
- Consultation or case management services by a **physician**.
 - Physical and occupational therapy.
 - Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
 - Medical supplies.
 - Drugs and medicines prescribed by a **physician**.

Charges made by the providers below for Outpatient Care, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
 - physical and occupational therapy;
 - part-time or intermittent home health aide services for up to 8 hours in any one day; these consist mainly of caring for the person;
 - medical supplies;
 - drugs and medicines prescribed by a **physician**; and
 - psychological and dietary counseling.

Not more than the Hospice Outpatient Maximum will be paid for all Hospice Care Expenses incurred while the person is not confined as a full-time inpatient.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Contraception Expenses

Covered Medical Expenses include:

- charges incurred for contraceptive drugs and contraceptive devices that by law need a physician's prescription; and that have been approved by the FDA.
- related outpatient contraceptive services such as:
 - consultations;
 - exams;
 - procedures; and
 - other medical services and supplies.

Not covered are:

- charges for services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your Employer; and
- charges incurred for contraceptive services while confined as an inpatient.

Infertility Services Expenses

Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for infertility if all of the following tests are met:

- There exists a condition that:
 - is a demonstrated cause of infertility; and
 - has been recognized by a gynecologist or infertility specialist who is a **Preferred Care Provider**; and
 - is not caused by voluntary sterilization or a hysterectomy;
- or
- The procedures are performed while not confined in a **hospital** or any other facility as an inpatient.

For a female who is:

- under age 35, she has not been able to conceive after one year or more without contraception; or
- age 35 or older, she has not been able to conceive after six months without contraception.
- FSH levels are less than or equal to 19 miU on day 3 of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

The following infertility services expenses will be Covered Medical Expenses:

- Ovulation induction.
- Artificial insemination.

These expenses will be covered as described in the Summary of Coverage.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Cryopreservation or storage of cryopreserved embryos.
- Gestational carrier programs.
- Home ovulation prediction kits.
- In vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and intracytoplasmic sperm injection.
- Frozen embryo transfers, including thawing.

Short-Term Rehabilitation Expenses

The charges made by:

- a **physician**; or
- a licensed or certified physical, occupational or speech therapist;

for the following services for treatment of acute conditions are Covered Medical Expenses.

Short-term rehabilitation is therapy which is expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to:

- an injury;
- a disease; or
- congenital defect.

Short-term rehabilitation services consist of:

- physical therapy;
- occupational therapy; or
- speech therapy

furnished to a person who is not confined as an inpatient in a **hospital** or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins.

The charges for Short-Term Rehabilitation services are Covered Medical Expenses for no longer than the Short-Term Rehabilitation Maximum Visits for each person during any one plan year.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an Employer.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services not performed by a **physician** or under his or her direct supervision.
- Services rendered by a physical, occupational, or speech therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services over age 7 rendered for the treatment of delays in speech development, unless resulting from:
 - disease;
 - injury; or
 - congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Spinal Manipulation Expenses section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Spinal Manipulation Expenses

Covered Medical Expenses include charges for treatment of spinal subluxation or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine.

Not more than the Spinal Manipulation maximum amount will be payable in any one calendar year.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;
- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Other Medical Expenses

These include:

- Charges made by a **physician**.
- Charges for the following:
 - Drugs and medicines which by law need a **physician's** prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
 - Diagnostic lab work and X-rays.
 - X-rays, radium, and radioactive isotope therapy.
 - Anesthetics and oxygen.
 - Allergy Serum and Injections.
 - Orthopedic shoes, foot orthotics and supportive devices.

Pumps for water circulating pad, water circulating cold pad with pump and pad for circulating heat unit.
Contact member services for additional information.

Rental of **durable medical and surgical equipment**. In lieu of rental, the following may be covered:

The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.

Repair of purchased equipment.

Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given.

Glucometers from an Aetna approved supplier.

Artificial limbs and eyes. Not included are charges for:

eyeglasses;

vision aids; and

communication aids.

Complex Imaging Services (High Tech Radiology)

Covered Medical Expenses include charges for Complex Imaging Services received by a covered person on an outpatient basis when performed in:

- (a) a physician's office
- (b) a Hospital outpatient department or emergency room; or
- (c) a licensed radiological facility

Complex Imaging Services include:

- (a) C.A.T. Scans;
- (b) Magnetic Resonance Imaging (MRIs);
- (c) Positron Emission Tomography (PET Scans); and
- (d) any other outpatient diagnostic imaging service costing over \$500.

Deductibles, copayments, other cost sharing features and exclusions apply.

Beginning Right™ Program

The Beginning Right™ Program provides you with maternity health care information, and guides you through pregnancy.

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and Beginning Right case managers. Contact Member Services at the toll-free telephone number on your ID card for additional information.

Aetna Compassionate CareSM A comprehensive program that offers service and support to members and their families who are facing difficult decisions about advanced illnesses. The program is comprised of nurse support, information and tools and enhanced hospice benefits to help remove barriers for needed care, promote choice and autonomy, and ensure that patients and their families receive comfort and support when dealing with an advanced illness. Requires physician to certify patient is not likely to live longer than **12 months**.

National Medical Excellence Program ® (NME)

The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses

These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses

These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

For the purpose of determining NME Travel Expenses or Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum

For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:

one year after the day the procedure is performed; and

the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Limitations

Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Explanation of Some Important Plan Provisions

Inpatient Hospital Copay

This is the amount of Inpatient Hospital Expenses you pay for each hospital confinement of a person.

The Inpatient Hospital Copay will only be applied once to all hospital confinements, regardless of cause, which are separated by less than 10 days.

Expenses used to meet the Inpatient Hospital Copay cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Hospital Copay.

Outpatient Hospital Copay

This is the amount of Outpatient Hospital Expenses you pay for each person.

Expenses used to meet the Outpatient Hospital Copay cannot be used to meet any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Outpatient Hospital Copay.

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each plan year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a plan year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Hospital Emergency Room Copay

A separate Hospital Emergency Room Copay applies to each visit for **emergency care**, by a person to a **hospital's** emergency room, unless the person is admitted to the **hospital** as an inpatient immediately following a visit to a **hospital** emergency room.

Outpatient Surgical Facility Copay

The Outpatient Surgical Facility Copay applies to all outpatient surgery performed in the outpatient department of a **Hospital** or Ambulatory Surgical Center. The Outpatient Surgical Facility Copay applies to Preferred Care.

Urgent Care Copay

A separate Urgent Care Copay applies to each visit for urgent care by a person to an **Urgent Care Provider** unless the person is admitted to the **hospital** as an inpatient immediately following a visit to an **Urgent Care Provider**.

Lifetime Maximum Benefit

This is the most that will be payable for any person in his or her lifetime.

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Limitations

Routine Mammogram

Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred by a female age 35 or over for a routine mammogram as follows:

- One baseline mammogram, for a person age 35 but less than 40.
- One mammogram each calendar year, for a person age 40 or over.

Mouth, Jaws and Teeth

Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

- services rendered; and
- supplies needed;

for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, "**physician**" includes a **dentist**.

Surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out:
 - teeth 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.

Dental Implants may be considered an eligible expense due to an injury, disease, rare medical condition, or illness that has prohibited tooth replacement by any other means (denture, bridge, etc.).

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

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

- natural teeth damaged, lost, or removed; or
- other body tissues of the mouth fractured or cut;

due to injury.

Any such teeth must have been:

- free from decay; or
- in good repair; and
- firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the plan year of the accident or the next one.

If:

- crowns (caps); or
- dentures (false teeth); or
- bridgework; or
- in-mouth appliances;

are installed due to such injury, Covered Medical Expenses include only 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.

Except as provided for injury, not included are charges:

- for in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;

-
- for root canal therapy;
 - for routine tooth removal (not needing cutting of bone).

Not included are charges:

- to remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- to repair, replace, or restore fillings, crowns, dentures or bridgework;
- for non-surgical periodontal treatment;
- for dental cleaning, in-mouth scaling, planing or scraping;
- for myofunctional therapy; this is:

muscle training therapy; or

training to correct or control harmful habits.

Family Planning

The charges made by:

- a **physician**; or
- a **hospital**;

for the following even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, are Covered Medical Expenses.

Benefits will be payable for:

- a vasectomy for voluntary sterilization; and
- a tubal ligation for voluntary sterilization.

Not covered are charges for the reversal of a sterilization procedure.

Emergency Room Treatment

Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is **emergency care**;

Covered Medical Expenses for charges made by the **hospital** for such treatment will be paid at the Payment Percentage.

Non-Emergency Care

If treatment:

- is received in the emergency room of a **hospital** while a person is not a full-time inpatient; and
- the treatment is not **emergency care**;

no benefits will be payable.

Treatment by an Urgent Care Provider

*You should not seek medical care or treatment from an **Urgent Care Provider** if your illness; injury; or condition; is an **emergency condition**. Please go directly to the emergency room of a **hospital** or call 911 (or the local equivalent) for ambulance and medical assistance.*

Urgent Care

This Plan pays for the charges made by an **Urgent Care Provider** to evaluate and treat an urgent condition.

When travel to an Urgent Care Provider for treatment of an urgent condition is not feasible, such treatment may be paid at the Preferred level of benefits. If a claim for treatment of an urgent condition is paid at the Non-Preferred level and you believe that it should have been paid at the Preferred level, please contact Members Services at the toll-free number on your I.D. card.

Non-Urgent Care

No coverage is provided for covered medical expenses for charges made by an Urgent Care Provider to treat a non-urgent condition.

Non-urgent care includes, but is not limited to, the following:

- routine or preventive care (this includes immunizations);
- follow-up care;
- physical therapy;
- elective surgical procedures; and
- any lab and radiologic exams which are not related to the treatment of the urgent condition.

Morbid Obesity Expenses

Covered Medical Expenses include charges made on an inpatient or outpatient basis by a **hospital** or a **physician** for the surgical treatment of **morbid obesity** of a covered person.

Coverage is included for one **morbid obesity** surgical procedure, including related outpatient services, within a two-year period, beginning with the date of the first **morbid obesity** surgical procedure, unless a multi-stage procedure is planned.

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Certification For Hospital Admissions

This certification section applies to admissions other than those for the treatment of alcoholism, drug abuse, or **mental disorders**. A separate section below applies to such admissions.

If:

- a person becomes confined in a **hospital** as a full-time inpatient; and
- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:

your **Primary Care Physician**; or

a **Preferred Care Provider**.

Covered Medical Expenses incurred on any day not certified during the confinement will be paid as follows:

- As to Hospital Expenses incurred during the confinement:

If certification has been requested and denied:

No benefits will be paid for Hospital Expenses incurred for board and room.

Benefits for all other Hospital Expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Hospital Expenses incurred for board and room.

As to all other Hospital Expenses:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for such expenses in excess of the Excluded Amount will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Hospital Expenses incurred for board and room, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Hospital Expenses will be payable at the Payment Percentage.

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- As to other Covered Medical Expenses:

Benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for a day of confinement, the exclusion of services and supplies because they are not **necessary** will not be applied to expenses for **hospital** room and board.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician** or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification for Convalescent Facility Admissions and Skilled Nursing Care

If a person incurs Covered Medical Expenses:

- while confined in a **convalescent facility**; or
- for a service or a supply while not confined as an inpatient or skilled nursing care; and

it has not been certified that:

- such confinement or any day of it is **necessary**; or
- such other services or supplies (either specifically or as a part of a planned program of care) are **necessary**, and
- the confinement or service or supply has not been ordered or prescribed by:

your **Primary Care Physician**; or

a **Preferred Care Provider**;

such Covered Medical expenses will be paid only as follows:

- As to Convalescent Facility Expenses while confined in a **convalescent facility**:

If certification has been requested and denied:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

Benefits for all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is not **necessary**:

No benefits will be paid for Convalescent Facility Expenses or Hospice Care Facility Expenses incurred for board and room.

As to all other Convalescent Facility Expenses or Hospice Care Facility Expenses incurred during the confinement:

Expenses, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses will be paid at the Payment Percentage.

If certification has not been requested and the confinement (or any day of such confinement) is **necessary**:

Convalescent Facility Expenses or Hospice Care Facility Expenses, incurred during the confinement, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other such expenses, incurred during the confinement, will be paid at the Payment Percentage.

As to all other Covered Medical Expenses incurred during the confinement, benefits will be paid at the Payment Percentage.

- As to Covered Medical Expenses incurred for services or supplies either as stated or as a part of a planned program of care for home health care, **hospice care** while not confined as an inpatient, or skilled nursing care:

If certification for a service or supply has been requested and denied or if certification has not been requested and the service or supply is not **necessary**, no benefits will be paid for the denied or unnecessary service or supply.

If certification has not been requested for a service or supply and the service or supply is **necessary**, benefits for the **necessary** service or supply will be paid as follows:

Expenses incurred for the service or supply, up to the Excluded Amount, will not be deemed to be Covered Medical Expenses.

Benefits for all other Covered Medical Expenses incurred for the service or supply will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan; except that:

- To the extent that a day of confinement has been certified, the exclusion of services and supplies because they are not **necessary** will not apply to:

Convalescent Facility Expenses for room and board; or

Hospice Care Facility Expenses for room and board.

- To the extent that such service or supply has been certified for home health care, **hospice care**, or skilled nursing care, the exclusion of services or supplies because they are not **necessary** will not apply to such service or supply.

To get certification you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified you must call to certify more days of confinement or services or supplies.

Prompt written notice will be provided to you of the days of confinement and services or supplies which have been certified.

If:

- services and supplies for **hospice care** provided to a person have been certified; and
- the person later requires confinement in a **hospital** for pain control or acute symptom management;

any other certification requirement in this Plan will be waived for any such day of confinement in a **hospital**.

You or the provider performing the procedure or treatment, must call the number shown on your ID card to request certification.

If the procedure or treatment is performed due to an **emergency condition**, the call must be made:

- before the procedure or treatment is performed; or
- not later than 48 hours after the procedure or treatment is performed; unless the call cannot be made within that time. In that case, the call must be made as soon as it is reasonably possible. In the event the procedure or treatment is performed on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If the procedure or treatment is performed for any condition other than an **emergency condition**, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Written notice of the certification decision will be sent promptly to you and the provider performing the procedure or treatment. This decision will be valid for 60 days from the date you receive the notice. If the procedure or treatment is to be performed after this 60 day period, certification must again be requested, as described above.

Certification For Hospital and Treatment Facility Admissions for Alcoholism, Drug Abuse, or Mental Disorders

If, in connection with the treatment of alcoholism, drug abuse, or a **mental disorder**, a person incurs Covered Medical Expenses while confined in a **hospital** or **treatment facility**; and

- it has not been certified that such confinement (or any day of such confinement) is **necessary**; and
- the confinement has not been ordered and prescribed by:

the BHCC; or

a **Preferred Care Provider** upon referral by the BHCC:

Covered Medical Expenses incurred on any day not certified during the confinement will be paid only as follows:

With respect to expenses for **hospital** and **treatment facility** board and room:

If certification has been requested and denied, or if certification has not been requested and the confinement (or any day of it) is not **necessary**, no benefits will be paid.

If certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

With respect to all other **hospital** and **treatment facility** expenses:

If certification has been requested and denied, or if certification has not been requested and the confinement is **necessary**, such expenses, up to the Excluded Amount, will not be Covered Medical Expenses.

If certification has not been requested and the confinement is not **necessary**, no benefits will be paid.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan; except that, if certification has been given for any day of confinement, the exclusions of services and supplies because they are not **necessary** will not be applied to **hospital** and **treatment facility** board and room.

To get the days certified, you must call the number shown on your ID card. Such certification must be obtained before confinement as a full-time inpatient, or in the case of an **emergency admission**, within 48 hours after the start of a confinement as a full-time inpatient or as soon as reasonably possible.

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, additional days of confinement must be certified. This must be done no later than on the last day that has already been certified.

Treatment of Alcoholism, Drug Abuse, or Mental Disorders

Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment

If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital

Expenses for the following are covered:

- Treatment of the medical complications of alcoholism or drug abuse. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Effective treatment of alcoholism or drug abuse.**
- Treatment of **mental disorders**.

Treatment Facility

Certain expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a private room over the **semiprivate rate**.
- Other **necessary** services and supplies.

Calendar Year Maximum Benefit

A Special Inpatient Plan Year Maximum Days applies to the **hospital** and **treatment facility** expenses described above.

Outpatient Treatment

If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Expenses for the **effective treatment of alcoholism or drug abuse** or the treatment of **mental disorders** are covered.

For such treatment given by a **hospital, treatment facility** or **physician**, benefits will not be payable for more than the Special Outpatient Calendar Year Maximum Visits in any one plan year.

General Exclusions

General Exclusions Applicable to Your Health Benefits

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be 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 disease or injury involved; or

if required by the FDA, approval 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, investigational, or for research purposes; 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, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

the disease can be expected to cause death within one year, in the absence of effective treatment; and

the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that:

have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or

are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;

if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.

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- Those for services and supplies:
Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

sildenafil citrate;
phentolamine;
apomorphine;
alprostadil; or
any other drug that

is in a similar or identical class,
has a similar or identical mode of action or exhibits similar or identical
outcomes.

- This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.
- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:

Improve the function of a part of the body that:

is not a tooth or structure that supports the teeth; and

is malformed:

as a result of a severe birth defect; including cleft lip, webbed fingers, or toes; or

as a direct result of:

disease; or

surgery performed to treat a disease or injury.

Repair an injury. Surgery must be performed:

in the plan year of the accident which causes the injury; or

in the next plan year.

Facings on molar crowns and pontics will always be considered cosmetic.

- Those to the extent they are not recognized charges, as determined by Aetna; except that this will not apply if the charge for a service or supply does not exceed the recognized charge for that service or supply by more than the amount or percentage specified in the Summary of Coverage as the Allowable Variation.
- Those for the reversal of a sterilization procedure.
- Those for a service or supply furnished by a **Preferred Care Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- Services and supplies which, in the opinion of the Claims Administrator or its authorized representative, are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.”

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. When this is the case, the benefits from "other plans" will be taken into account. This may mean a reduction in benefits under this Plan. The combined benefits will not be more than the expenses recognized under these plans.

In a plan year, this Plan will pay:

- its regular benefits in full; or
- a reduced amount of benefits. To figure this amount, subtract B. from A. below:
 - A. 100% of "Allowable Expenses" incurred by the person for whom claim is made.
 - B. The benefits payable by the "other plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any **necessary** and reasonable health expense, part or all of which is covered under any of the plans covering the person for whom claim is made.

The difference between the cost of a private **hospital** room and the **semiprivate rate** is not considered an Allowable Expense under the above definition unless the patient's stay in a private **hospital** room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

To find out whether the regular benefits under this Plan will be reduced, 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 plan year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that plan 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
- a 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.

Aetna has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a plan year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

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.

Effect of A Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an Eligible Class and have chosen coverage under an HMO Plan offered by your Employer, you and your eligible dependents will be excluded from Health Benefits Coverage (except Vision Care, if any) on the date of your coverage under such HMO Plan.

If you are in an Eligible Class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this Plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the first day of the contract period which follows the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when Aetna gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when the Aetna gives its written consent.

Any extensions of benefits under this Plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this Plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- the end of a 90 day period; and
- the date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Effect of Medicare

Medical Coverage under this Plan will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
 - having refused it;
 - having dropped it; or
 - having failed to make proper request for it.

These are the changes:

- This Plan will pay:
 - its full benefits; or
 - a reduced amount.
- The amount this Plan will pay will be figured so that this amount, plus the benefits under Medicare, will equal 100% of "Plan Expenses". "Plan Expenses" means any **necessary** and reasonable health expenses, part or all of which is covered under this Plan.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.
- Any benefits under Medicare will not be deemed to be an "Allowable Expenses".

If it is necessary in order to administer this provision, Aetna has the right to:

release or obtain data and make or recover any payments.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be determined before benefits are available under Medicare.

Effect of Prior Coverage - Transferred Business

If the coverage of any person under any part of this Plan replaces any prior coverage of the person, the rules below apply to that part.

"Prior coverage" is any plan of group accident and health coverage that has been replaced by coverage under part or all of this Plan; it must have been sponsored by your Employer (i.e., transferred business). The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this Plan.

Coverage under any section of this Plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this Plan.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next service fee due date following the date you cease active work. Your Employer will use the same rule for all employees. If you are not at work on this date due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or injury, your employment may be continued until stopped by your Employer, but not beyond 30 months from the start of the absence.

If you are not at work due to temporary lay-off or leave of absence, your employment may continue until stopped by your Employer, but not beyond the end of the calendar month after the calendar month in which the absence started. The Summary of Coverage may show an Eligible Class of retired employees. If you are in that class, your employment may be deemed to continue:

- for any coverage shown in the Retirement Eligibility section; and
- subject to any limits shown in that section.

If no Eligible Class of retired employees is shown, there is no coverage for retired employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under this Plan.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.
- The end of the calendar month in which the dependent child turns age 25.

Handicapped Dependent Children

Health Benefits Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; 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.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.

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- Failure to have any required exam.
 - Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

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.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

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

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Additional Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Subrogation and Right Of Recovery Provisions

Definitions

As used throughout this provision, the term **Responsible Party** means any party actually, possibly, or potentially responsible for making any payment to a **Covered Person** due to a **Covered Person's** injury, illness or condition. The term **Responsible Party** includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term **Insurance Coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage or any first party insurance coverage.

For purposes of this provision, a **Covered Person** includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a **Covered Person** has against any **Responsible Party** with respect to any payment made by the **Responsible Party** to a **Covered Person** due to a **Covered Person's** injury, illness or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement

In addition, if a **Covered Person** receives any payment from any **Responsible Party** or **Insurance Coverage** as a result of an injury, illness or condition, the plan has the right to recover from, and be reimbursed by, the **Covered Person** for all amounts this plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount the **Covered Person** receives from any **Responsible Party**.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees that if he/she receives any payment from any **Responsible Party** as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the **Covered Person's** fiduciary duty to the plan.

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 for which **Responsible Party** is liable. The lien shall be imposed 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, the **Covered Person**; the **Covered Person's** representative or agent; **Responsible Party**; **Responsible Party's** insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan or the plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** acknowledges that this plan's recovery rights are a first priority claim against all **Responsible Parties** and are to be paid to the plan before any other claim for the **Covered Person's** damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any **Responsible Party's** payments, even if such payment to the plan will result in a recovery to the **Covered Person** which is insufficient to make the **Covered Person** whole or to compensate the **Covered Person** in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the **Covered Person** to pursue the **Covered Person's** 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 by any **Responsible Party** and regardless of whether the settlement or judgment received by the **Covered Person** 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.

Cooperation

The **Covered Person** shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the **Covered Person** 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 the **Covered Person's** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the **Covered Person**. The **Covered Person** and his/her 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. Failure to provide this information may result in the termination of health benefits for the **Covered Person** or the institution of court proceedings against the **Covered Person**.

The **Covered Person** 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.

The **Covered Person** acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any **Responsible Party**. The plan reserves the right to notify **Responsible Party** and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

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 (whether the payment of such benefits is made to the **Covered Person** or made on behalf of the **Covered Person** to any provider) from the plan, the **Covered Person** agrees 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, the **Covered Person** hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Discount Programs

Incentives

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

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; 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 this 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. Your Employer has claim forms.

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

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 will not be covered if they are filed more than 2 years after the deadline.

Fraud or Misrepresentation

Anyone who commits fraud or make misrepresentations with regards to the use of Group Health and Related Benefits loses coverage as outlined in the respective benefit plan documents. Further, the County will report all suspected cases of fraud to the District Attorney .

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received.

All benefits are payable to Preferred Care Providers or to you. However, this Plan has the right to pay any health benefits to the service provider.

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

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.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Behavioral Health Provider

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

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Board and Room Charges

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

Body Mass Index

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

Brand Name Drug

A **prescription drug** which is protected by trademark registration.

Companion

This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility

This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
 - professional nursing care by a **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 **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.
- Makes charges.

Copay

This is a fee, charged to a person, which represents a portion of the applicable expense. It is specified in the Summary of Coverage.

As to a **prescription drug** dispensed by a **preferred pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed.

As to a **prescription drug** dispensed by a **non-preferred pharmacy**, this is the amount by which the total charge for the **prescription drug** is reduced before benefits are payable.

For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.

Custodial Care

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory

This is a listing of **Preferred Care Providers** in the **Service Area** covered under this Plan, which is given to your Employer for distribution to all employees covered under this Plan. A current list of participating providers is also available through Aetna's on-line provider directory, DocFind, at www.aetna.com.

Durable Medical and Surgical Equipment

This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;
- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

Effective Treatment of Alcoholism Or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Effective Treatment of A Mental Disorder

This is a program that:

- is prescribed and supervised by a **physician**; and
- is for a disorder that can be favorably changed.

Emergency Admission

One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and

-
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:

- placing the person's 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.

Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Emergency Condition

This means 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, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's 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.

Generic Drug

A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency

This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or a **R.N.**; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan

This is a plan that provides for care and treatment of a disease or injury.

The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice: As defined by Medicare, a program that provides palliative care (comfort and support) for those who are terminally ill. Traditionally, it has been available only to those with a life expectation of six months or less who agree to forego curative treatments.

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

This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
 - skilled nursing services; and
 - medical social services; and
 - psychological and dietary counseling.
- Provides or arranges for other services which will include:
 - services of a **physician**; and
 - physical and occupational therapy; and
 - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and
 - inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
 - one **physician**; and
 - one **R.N.**; and
 - one licensed or certified social worker employed by the Agency.
- Establishes policies governing the provision of **Hospice Care**.
- 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.
- Utilizes 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.
- 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

This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.

-
- Charges its patients.
 - Meets any licensing or certification standards set forth by the jurisdiction where it is.
 - 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 such **physician** must be on call at all times.
 - Provides, 24 hours a day, nursing services under the direction of a **R.N.**
 - Has a full-time administrator.

Hospital

This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.
- Makes charges.

L.P.N.

This means a licensed practical nurse.

Late Enrollee

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

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

Mail Order Pharmacy

An establishment where **prescription drugs** are legally dispensed by mail.

Mental Disorder

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

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.

NME Patient

This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and

-
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
 - agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge

This is the maximum charge a **Preferred Care Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease 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 disease under such law.

Non-Occupational Injury

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

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

Non-Preferred Care

This is a health care service or supply furnished by a health care provider that is not **Preferred Care**.

Non-Preferred Care Provider

A health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge**.

Non-Preferred Pharmacy

A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Non-Specialist

A **physician** who is not a **specialist**.

Non-urgent Admission

One which is not an **emergency admission** or an **urgent admission**.

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.

Not included is:

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

Outpatient Surgical Treatment

Surgical treatment furnished in a surgery center to patients who:

- do not require hospitalization; but
- require constant medical supervision following the surgical procedure performed.

Palliative care: Care to relieve physical symptoms of disease, without regard to cure for terminal illnesses. Also provides emotional and spiritual support to patients and family members.

Pharmacy

An establishment where **prescription drugs** are legally dispensed.

Physician

This means a legally qualified physician.

Preferred Care

This is a health care service or supply furnished by:

- A person's **Primary Care Physician** or any other **Preferred Care Provider**.
- A **Non-Preferred Care Provider** on the referral of the person's **Primary Care Physician** and if approved by Aetna.
- Any health care provider for an **emergency condition** when travel to a **Preferred Care Provider** or referral by a person's **Primary Care Physician** prior to treatment is not feasible and
- A Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible.

Preferred Care is also care which is recommended and approved by the BHCC.

Preferred Care Provider

This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a Preferred Care Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

Preferred Pharmacy

A **pharmacy**, including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

Prescriber

Any person, while 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 of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs

Any of the following:

- A drug, biological, compounded **prescription** or contraceptive device which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable contraceptive drug prescribed to be administered by a paid healthcare professional.
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

Primary Care Physician

This is the **Preferred Care Provider** who is:

- selected by a person from the list of Primary Care Physicians in the **Directory**;
- responsible for the person's on-going health care; and
- shown on Aetna's records as the person's Primary Care Physician.

Psychiatric Physician

This is a **physician** who:

- specializes in psychiatry; or
- has the training or experience to do the required evaluation and treatment of mental illness.

R.N.

This means a registered nurse.

Recognized Charge

Only that part of a charge which is less than or equal to the **recognized charge** is a **covered benefit**. The **recognized charge** for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge **Aetna** determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
 - a. For non-facility charges: 125% of the Medicare Resource Based Relative Value Scale (RBRVS).
 - b. For facility charges: **Aetna** uses the **Aetna** Facility Fee Schedule for the geographic area where the service is furnished.
- For **prescription drugs**: 110% of the **Average Wholesale Price (AWP)** or other similar resource. **Average Wholesale Price (AWP)** is the current **average wholesale price** of a **prescription drug** listed in the Medi-Span weekly price updates (or any other similar publication chosen by **Aetna** on the day that a **pharmacy** claim is submitted for adjudication.

In determining the **recognized charge** for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of **providers** in the geographic area;

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the **provider**;
- The range of services or supplies provided by a facility; and
- The **recognized charge** in other geographic areas.

In some circumstances, **Aetna** may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply. In these instances, in spite of the methodology described above, the **recognized charge** is the rate established in such agreement.

As used above, the term “geographic area” means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

Self-injectable Drug(s)/Specialty Drugs

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions. This does not include insulin. Contact member services for additional information regarding specialty drugs.

Semiprivate Rate

This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate. It will be 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 **Preferred Care Providers** for this Plan are located.

Specialist

A physician who:

practices in any generally accepted medical or surgical sub-specialty; and is providing other than routine medical care.

A physician who:

practices in such a sub-specialty; and is providing routine medical care (such as could be given by a **primary care physician**),

will not be considered a Specialist for purposes of applying this plan's **copay** provisions.

Specialty Pharmacy Network

A network of **preferred pharmacies**, vendors and suppliers designated by this Plan to fill **self-injectable drug prescriptions** and blood clotting factor.

Surgery Center

This is a freestanding ambulatory surgical facility that:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Makes charges.
- 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 which requires 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 a **R.N.**
- Is equipped and has trained staff to handle medical emergencies.
- It must have:
 - 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

A medical prognosis of 12 months or less to live.

Treatment Facility (Alcoholism Or Drug Abuse)

This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **effective treatment of alcoholism or drug abuse**.

-
- Makes charges.
 - Meets licensing standards.
 - Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
 - Provides, on the premises, 24 hours a day:

Detoxification services needed with its effective treatment program.

Infirmiry-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.

Supervision by a staff of **physicians**.

Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Treatment Facility (Mental Disorder)

This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmiry-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 psychiatrist 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 care 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.

Urgent Admission

One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, 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 Provider

This is:

- A freestanding medical facility which:

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.

Makes charges.

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 Preferred 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 the covered person's health;
- includes a condition which would subject the covered person 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 the covered person's **physician** becomes reasonably available.

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a **physician**. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a **Walk-in Clinic**.

Continuation of Coverage under Federal Law

The terms of this continuation of coverage provision do not apply to the Plan of any Employer that employs fewer than 20 employees, in accordance with a formula mandated by federal law. Check with your Employer to determine if this continuation of coverage provision applies to this Plan.

In accordance with federal law (PL 99-272) as amended, your Employer is providing covered persons with the right to continue their health expense coverage under certain circumstances.

You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage, or, as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month.

Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

Continuation shall be available as follows:

A. Continuation of Coverage on Termination of Employment or Loss of Eligibility

If your coverage would terminate due to:

- termination of your employment for any reason other than gross misconduct; or
- your loss of eligibility under this Plan due to a reduction in the number of hours you work;

you may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue his or her own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event which would have caused coverage to terminate.
- The end of a 29-month period after the date of the event which would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to your Employer, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event which would have caused coverage to terminate. Coverage may be continued: for the individual determined to be disabled; and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued; and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to you under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare. This will not apply if contrary to the provisions of the Medicare Secondary Payer Rules or other federal law.
- As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled; but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage Under Other Circumstances

If coverage for a dependent would terminate due to:

- your death;
- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- the dependent's ceasing to be a dependent child as defined under this Plan; or
- the dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare;

the dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date your Employer informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event which would have caused coverage to terminate.
- The date that the group contract discontinues in its entirety as to health expense coverage. However, continued coverage may be available to your dependents under another plan sponsored by your Employer.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

C. Multiple Qualifying Events

If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months.

Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

D. Notice Requirements

If coverage for you or your dependents:

- is being continued for 18 months in accordance with section A; and
- it is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of, the event in section A which would have caused coverage to terminate;

you or your dependent must notify your Employer of such determination within 60 days after the date of the determination, and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- your divorce;
- your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- the dependent's ceasing to be a dependent child as defined under this Plan;

you or your dependent must provide notice to your Employer of the occurrence of the event. This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event.

If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

E. Other Continuation Provisions Under This Plan

If this Plan contains any other continuation provisions which apply when health expense coverage would otherwise terminate, contact your Employer for a description of how the federal and other continuation provisions interact under this Plan.

Complete details of the federal continuation provisions may be obtained from your Employer.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Benefits Coverage for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer 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 your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If 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 your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

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

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Additional Information Provided by Harris County

Claim Procedures

Your booklet contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal in a shorter timeframe, the shorter period will apply.

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an 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. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means 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, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

"A claim involving urgent care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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 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 the Plan'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 the Plan'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 a Plan 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 Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision 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.

Filing an Appeal of an Adverse Benefit Determination

Health Claims – Standard Appeals

As a member of an Aetna Health Plan, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

You may file an appeal in writing to Aetna. The denial notice will include the address where the appeal can be sent. 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, Social Security Number 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.

Your appeal will be acknowledged within five working days of receipt. 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 decision to appeal the decision 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 the Plan 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 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 the Plan 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 a claim involving urgent care, 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.

Health Claims – Voluntary Appeals

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

You must complete all of the levels of standard appeal described above before you can appeal for external review. 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 must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes.

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.

Appeal for External Review

Aetna's external review process gives members the opportunity to have certain coverage denials reviewed by independent physician reviewers. An appeal will be eligible for external review if the following are satisfied:

- the standard levels of appeal have been exhausted,
- the appeal is made by the member or the member's authorized representative,
- the coverage denial is based on Aetna's determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- the cost of the service or supply at issue for which the member is financially responsible exceeds \$500.

If upon the final standard level of appeal Aetna upholds the coverage denial and it is determined that the member is eligible for external review, the member will be informed in writing of the steps necessary to request an external review.

An independent review organization (IRO) refers the case for review by a neutral, independent physician with appropriate expertise in the area in question. Once all necessary information is submitted, the external review requests will generally be decided within 30 days of the request. Expedited reviews are available when a member's physician certifies that a delay in service would jeopardize the member's health. The decision of the independent external expert reviewer is binding on Aetna, the Company and the Health Plan. Members will not be charged a professional fee for the review.

Additional Information

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Plan requires certification of any confinement, services, supplies, procedures, or treatments:

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers by calling the toll - free Member Services number on your ID Card. A current list of providers in the Aetna network is available through DocFind[®], at www.aetna.com.

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, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

- (1) reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) 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 subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

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