Summary Plan Description
Prepared Exclusively for Columbia University in the City of New York Officers
Aetna Choice POS II HDHP

Aetna
Effective: January 1, 2014
Group Number: 619362

January 2014
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Introduction

Columbia University in the City of New York is pleased to provide you with this Summary Plan Description (SPD), which describes the health benefits available to you and your covered family members under the Columbia University in the City of New York Group Benefits Plan. It includes summaries of:

- Who is eligible
- Services that are covered, called Covered Health Services
- Services that are not covered, called Exclusions
- How benefits are paid
- Your rights and responsibilities under the Medical Plan

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan – including previously released Benefits in Brief, and Benefits Highlights. You are responsible for using this SPD and other resources provided to you to understand your benefits.

The rest of this description provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words “you” and “your” refer to eligible covered persons enrolled in the Plan.

If there is a conflict between this SPD and any summaries provided to you and/or any verbal representations, this SPD will govern in every respect and instance.

How to Use This SPD

- Please read the entire SPD and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.hr.columbia.edu or request printed copies by contacting the Columbia Benefits Service Center at 212-851-7000.

Overview of the Medical Plans

Columbia University in the City of New York offers choices of medical plans so that you can select the option that best meets the needs of you and your family.

What the Plans Cover

All the healthcare plans cover medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental disorder, substance use disorder or symptoms.

Only certain preventive care services are covered. The plans do not cover treatment for chronic care or conditions. All plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Exclusions.” Columbia University in the City of New York and all its medical carriers administering the Plans, assume no responsibility for the outcome of any covered services or supplies.
The Plans described in the following pages of this Booklet are a benefit plan provided by Columbia University in the City of New York. These benefits are not insured with Aetna or any of their affiliates but are paid from Columbia University in the City of New York funds. Aetna, provide certain administrative services under the Plan including claim determination, application of copays, coinsurance and limitations.

The Plans differ in how benefits are determined when you have covered expenses. A description of how each plan determines benefits follows in the sections, “Covered Services” and “Exclusions.”

The medical benefits plan described in this Booklet is a benefit plan of the Employer. These benefits are not insured with 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 Aetna medical benefits plan.

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

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

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

**Medically Necessary Services**

The Plan covers only medically necessary services and supplies that are provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental disorder, substance use disorder or symptoms subject to the terms and conditions of the selected medical plan. In addition, certain preventive care services are covered within limitations.

For a service or supply to be considered medically necessary, it must be:

- Ordered by a licensed physician
- Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)
- Consistent with the diagnosis of the condition
- Required for reasons other than the convenience of the patient or his/her physician
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator
- Other than experimental or educational in nature

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, illness or pregnancy does not mean that it is a medically necessary service or supply as defined above. The definition of “medically necessary” used in this SPD relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.
Claim Filing Deadline
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.

You have 12 months to submit a claim for a covered service to your health plan. While most in-network providers automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you receive services from an out-of-network provider, you are responsible for submitting your claim for a covered service within the 12 months from the date of service.

Coverage for Maternity Hospital stay
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the ‘Newborns’ and Mothers’ Health Protection Act” 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 cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Group Plan Coverage Instead of Medicaid
If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

Notice of Provider Directory/Networks
Notice Regarding Provider Directories and Provider Networks
If your Plan utilizes a network of Providers, you will have access to a list of Providers who participate in the network by visiting their website or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with Aetna HealthCare.

Pre-Existing Conditions
There are no pre-existing condition limits under the Columbia University in the City of New York Group Benefits Plan.

Preauthorization Requirements
Certain procedures, services and/or supplies require you to obtain preauthorization from your selected medical claim administrator for you to receive the maximum benefits under the plan. You must get
authorization for certain procedures and treatments before the procedure is performed or before the treatment starts; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the preauthorization section in Aetna coverage descriptions.

Financial Penalty If You Do Not Get Preauthorization

With all plans, you must obtain preauthorization before receiving certain services; otherwise, your benefits will be significantly reduced. Note that each health plan may call this process something different including “pre-certification”, “prior authorization”, and “Personal Health Support Notification”. If you do not obtain preauthorization as required, the Plan will significantly reduce payment for all expenses related to the condition, and your additional cost will not count toward your out-of-pocket maximum. Become familiar with the specific services that require preauthorization based on whether your plan’s claims administrator is Aetna. If you have questions, call your plan’s member services (phone number on your member ID card).

Overview of Point-of-Service (POS) Plans

You can select this type of benefit coverage from several POS plans – Aetna. Each one has a network of participating hospitals, physicians and other healthcare providers who have agreed to accept lower negotiated fees for services and supplies for eligible patients. When you use providers who are in the POS network, your cost toward healthcare expenses is lower.

In-Network Services

When you use a provider who participates in the POS network, you do not have to submit claim forms to receive reimbursement for your expenses. The POS plan pays the provider directly. In addition, if the charges exceed the network negotiated rates, you are not responsible for the difference in cost. Participating network providers are not permitted to bill you for any balance.

Out-of-network services

POS plans allow you the flexibility to use providers who are not in the network - at any time. However, your cost toward your healthcare expenses is significantly higher because there are no negotiated fees. In addition, the POS plans limit the amount they will pay for any service obtained outside of the network. The reimbursement is indexed to 190% of the Medicare Maximum Allowable Charge. **You are responsible for paying the full amount of any charges that exceed this limit.**

In addition, you must file claim forms with your medical carrier for each service or supply and wait for reimbursement.

Administrative and Legal Information about the Plan

**Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP,
you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

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<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Medicaid</th>
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<tr>
<td>Phone: 1-855-692-5447</td>
<td>Medicaid Phone (In state): 1-800-866-3513</td>
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<td>Medicaid Phone (Out of state): 1-800-221-3943</td>
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<tr>
<td>Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a></td>
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<tr>
<td>Phone (Outside of Anchorage): 1-888-318-8890</td>
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<td>Phone (Anchorage): 907-269-6529</td>
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<tr>
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<td>Website: <a href="http://www.azahcccs.gov/applicants">http://www.azahcccs.gov/applicants</a></td>
<td>Website: <a href="https://www.flmedicaidtplrecovery.com">https://www.flmedicaidtplrecovery.com</a></td>
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<tr>
<td>Phone (Outside of Maricopa County): 1-877-764-5437</td>
<td>Phone: 1-877-357-3268</td>
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<td>Phone (Maricopa County): 602-417-5437</td>
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<tr>
<td>Phone: 1-800-869-1150</td>
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To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  U.S. Department of Health and Human Services
Employee Benefits Security Administration  Centers for Medicare & Medicaid Services
1-866-444-EBSA (3272)  1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)
1-866-444-EBSA (3272) [www.cms.hhs.gov](http://www.cms.hhs.gov)  1-877-267-2323, Ext. 61565

**Your Privacy Rights**

**Health Insurance Portability & Accountability Act (HIPAA)**

**Notice of Privacy Practices For Protected Health Information**

With the growth of information technology, the protection of private medical information has become a national concern. Congress addressed these concerns with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whose privacy provisions, applicable to all health plans providers, went into effect on April 14, 2003.
Disclosure Limitations

The Federal Health insurance Portability and Accountability Act and related privacy rules requires Columbia University in The City of New York to keep your health information private. The Columbia University Health Plan – which includes Aetna HDHP and its HSA, Aetna POS, Cigna OAP, Cigna POS, United Healthcare POS, Cigna International, Express Scripts Rx, the Aetna Columbia Dental Plan, and the Healthcare Flexible Spending Account – has always maintained the strictest privacy and confidentiality standards in the use and handling of your health insurance information.

Under HIPAA, health plan providers and designated Columbia University Human Resources employees can only disclose your protected health information for a limited number of purposes:

- To make or obtain payments
- To conduct healthcare operations
- To recommend treatment alternatives
- To provide information about health related benefits and services
- To communicate with an individual – that is, a friend or family member – involved in your care or the payment for your care (if authorized by you)
- To comply with a federal, state or local requirement
- To comply with a court order or administrative proceeding
- To conduct health oversight activities
- To counter serious threats to your health or safety
- For law-enforcement purposes
- For specified government functions
- For worker’s compensation
- To disclose your information to you
- To third party non- Columbia business associates that perform services for us or on our behalf, such as vendors
- To a medical examiner for the purpose of identifying a deceased person, determining the cause of death, or other duties authorized by law
- To use or disclose your private health information to assist entities engaged in the procurement, or transplantation of cadaver organs, eyes, or tissue

Otherwise, neither the health plan providers nor Columbia University Human Resources can disclose information about your or your dependents’ health insurance, dental insurance, prescription drug coverage, healthcare FSA, HSA or medical plan enrollment with anyone other than the covered individual. This includes:

- Other offices of the University, as well as employees in Columbia Human Resources not involved in health plan administration
- Spouses or other family members not directly involved in your care or the payment for your care (unless authorized by you)

Your rights regarding your health information include:
• The right to request restrictions beyond those outlined above
• The right to receive confidential communications (for example) at only a specified phone number or email address
• The right to inspect and copy your private health information
• The right to be notified in the event the plan(or a business associate) discovered a breach of unsecured protected health information
• The right to prohibit the use of genetic information for underwriting purposes, except for underwriting for long term care policies

The right to a paper copy of the Notice of Columbia University Health Plan’s Privacy Practices, sent to all Columbia employees on April 14, 2003, distributed to all subsequent new hires, and available on the web at www.hr.columbia.edu/benefits.

**Privacy Officer**  
To exercise your HIPAA rights under Columbia Health plans, please contact Columbia’s designated Privacy Officer at:

**Privacy Officer**  
Columbia Benefits  
Studebaker 4th Floor, MC 8705  
615 West 131st Street  
New York, NY 10027  
Email: hrprivoff@columbia.edu  
Secure Fax: 212-851-7025

Or

The Federal Secretary of the Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**Authorization Forms**  
For HIPAA authorization forms, please visit the HR website at [www.hr.columbia.edu/forms-docs/forms](http://www.hr.columbia.edu/forms-docs/forms).

**If You Have Questions**  
For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Office are available through EBSA’s website.)
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option.

The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:
  - Employee only;
  - Spouse only;
  - Employee and spouse;
  - Dependent child(ren) only; Employee and Dependent child(ren);
  - Employee, spouse and Dependent child(ren).

  Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be
exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:

- due to failure of the employer or other responsible entity to remit premiums on a timely basis;
- when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or
- when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual.

This does not include termination of an employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be denied enrollment. You will not be enrolled in this plan if you do not enroll within 31 days of the date you become eligible, unless you are eligible for special enrollment.

**Your ERISA Rights**

As a participant in the medical (including prescription drug), dental, flexible spending accounts, health savings account long-term disability and life insurance benefits described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to receive a yearly summary of each plan’s financial report. You may examine all the official documents related to the Plans in the Columbia University of the City of New York Benefits department. If you wish, you can obtain your own copies of Plan documents by writing to hrbenefits@columbia.edu. You may have to pay a reasonable charge to cover the cost of postage and photocopying.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who administer the plans. These people are called “fiduciaries” and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person or organization, may terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining your Plan benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for a welfare benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. For the medical, dental, life and long-term disability plans, the reason for the denial is explained in the Explanation of Benefits (EOB) or denial letter. (Please see the section Claim Review and Appeals Procedures under each Plan.) For the other plans covered under ERISA, you have the right to have the Plan Administrator review and reconsider the claim by submitting a request for appeal within 60 days of the denial. The request may be made by you or your authorized representative and should include the reason you are requesting a review of the claim, as well as any additional information that supports your claim. A review of your claim will take place no later than 120
days after receipt of your appeal. If your claim is still denied, you may file suit in a state or federal court. If you have any questions about your rights under ERISA, you may contact the nearest office of the U.S. Department of Labor.

**Women's Health and Cancer Rights Act (WHCRA)**

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

**Obtaining a Certificate of Creditable Coverage**

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will automatically be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, call the toll-free customer service number on the back of your ID card.

**Statement of the University's Rights**

This document is not a contract or agreement for employment. Employment with Columbia University in the City of New York is “at-will” for officers of administration—nothing in this document changes your right and the University’s right, to end your employment at any time and for any reason. Employment at Columbia University in the City of New York is not guaranteed for any period of time.

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the claims administrators for the medical plans. As the Plan Administrator’s delegates, the claims administrators have the authority to make decisions relating to benefit claims.

The University intends that the terms of the Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

Although Columbia University in the City of New York expects to continue the Plan, it reserves the right to amend, modify or discontinue all or any part of the Plan or any plan or coverage at any time for any or all employees including active, disabled and former employees participating in the Columbia University in the City of New York Group Benefits Plan. In the event of termination of the Plan, no benefits will be paid for incidents or events occurring after the date of termination.

No oral or written communication will be effective in amending the Plan unless it is by way of a formal amendment. Complete details, terms and conditions relating to each element of the plans are contained in the relevant plan documents; the specific provision and language of these documents will govern in every respect and instance.

To the extent this SPD provides a general description of the tax results that may be applicable to coverage under the Plan, Columbia University in the City of New York assumes no responsibility for your
own personal tax status, or for any tax consequences resulting from any claims made contrary to current
tax law. Please consult your tax advisor for further information on the tax treatment of your benefits.

**Plan Information**

The name of the Plan is:
Columbia University in the City of New York Group Benefits Plan

**Plan Name**

Aetna Choice POS II HDHP

**Plan Sponsor and Administrator**

Columbia University in the City of New York is the Plan Sponsor and Plan Administrator of the Columbia
University Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact
the Plan Administrator at:

Plan Administrator – Group Benefits Plan
Columbia University in the City of New York
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

**Employer Identification Number (EIN):** 13-5598093

**Plan Identification Number:** 515

The name, address and ZIP code of the person designated as agent for the service of legal process is:
Employer named above

The office designated to consider the appeal of denied claims is:
The Claim Office of your selected health plan (e.g., Aetna). The phone number is listed on your member
Identification card.

The cost of the Plan is shared by the Employee and Employer.

The Plan year is calendar and ends on 12/31.

**Plan Trustees**

A list of Trustees of the Plan, which includes name, title and address, is available upon request to the
Plan Administrator.

**Plan Type**

The plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or
more collective bargaining agreements. A copy is available for examination from the Plan Administrator
upon written request.
Claim Administrator
The Plan Administrator delegates to your selected health plan (e.g., Aetna, Express Scripts) the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to your selected health plan the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

The role of the Claims Administrator is to handle the day-to-day administration of the Plan’s coverage as directed by the Plan Administrator, through an administrative agreement with the University. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor’s Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor’s Plan.

Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan’s Agent of Service is:

Agent for Legal Process – Group Benefits Plan
Columbia University in the City of New York
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

Type of Administration
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name: Columbia University Group Benefits Plan
Plan Number: 515
Employer ID: 13-5598093
Plan Type: Welfare benefits plan
Plan Year: Calendar
Plan Administration: Self-Insured
Source of Plan Contributions: Employee and University
Source of Benefits: General Assets of the University
Eligibility for Benefit Coverage

Eligibility for Full-Time Officers
If you are a full-time active Columbia University Officer, you and your family are eligible for medical coverage under the Columbia University in the City of New York Group Benefits Plan.

Benefits for Part-Time Officers of Administration
As a regular part-time Officer of Administration, you are eligible to participate in the Columbia University in the City of New York Group Benefits Plan, provided you meet the following requirements:

- You are a regular Officer of Administration
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week
- You are a Grade 10 position or higher at Morningside, Lamont or Nevis
- You are a Grade 103 or higher at Columbia University Medical Center

Regular part-time positions are those without a planned employment end date.
Temporary part-time employees are not eligible for part-time benefits. Temporary positions are those approved for a temporary period of time and have an employment end date.

When Your Benefits Start
You are eligible for benefits on your date of hire. In order for your benefits to be effective on your date of hire, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any group health plan coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns
Any Dependent child born while you are covered under one of the Columbia University in the City of New York health plans (Aetna) will automatically be covered on the date of his or her birth for a period of 31 days. However, you must enroll your newborn in your coverage no later than 31 days after the birth. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits to report the birth; if you need assistance, call the Columbia Benefits Service Center at 212-851-7000. If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Your Eligible Dependents
You can also elect to cover your dependents. Your eligible dependents include your:

- Legal Spouse
- Same-sex Domestic Partner and your partner is:
  - At least 18 years old
  - Not related to you by blood
  - Not legally married to another person
In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as marriage.

And meets two or more of the following requirements:

- Shares the same principal residence with you full-time and for the past 12 continuous months.
- Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
- Has power of attorney for medical purposes.

Legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:

- Until the end of the month in which they turn 26;
- If a court has appointed you legal guardian (for any child from birth to 26); and
- At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for benefits or prior to the end of the Plan month in which the dependent turns age 26. Approval by your medical insurance carrier (Aetna) is required. See How to Continue Coverage for a Disabled Child, below.

Eligible dependent children do not include:

- a dependent who is employed by the University; or
- injuries occurring during military service.

How to Continue Coverage for a Disabled Child

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 26:

- If you’re an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the month in which he or she turns age 26.
- If you’re a newly eligible employee and your disabled child is older than age 26 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 26, you must complete and submit the required form(s) to your medical plan carrier—Aetna. Forms are available from the Columbia Benefits Service Center at 212-851-7000.

Your medical carrier may request that you provide proof of your child’s incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to your medical carrier within the requested timeframe or the Plan will no longer pay benefits for that child.

Who is Not Eligible for the Plan

The term “employee” in this document does not include:

- Officers whose appointments are incidental to their educational program at the University.
• Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures
• Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the Medical Plan
• Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University’s employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.
• Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.
• An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).
• Temporary employees.

You Are Responsible for Covering Only Eligible Dependents
You are responsible for ensuring that only your eligible dependents are enrolled in the Medical and Dental Plans. An employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a former spouse or a child over the age limit), the dependent will not be covered by the Plan for any medical and/or dental expenses incurred while he or she was ineligible.

You will be required to repay all costs to the University of providing coverage and any benefits paid to you. Also, if you don’t notify the University when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

Report Changes in Dependent Eligibility
When a dependent is no longer eligible, it is your responsibility to report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits and update any changes in the status of your dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

Proof of Eligibility
Columbia University in the City of New York has a responsibility to ensure that only eligible expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, social security number, a marriage certificate, etc. If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.
You Choose Who to Cover Under Your Benefits
You must select from one of the following coverage options to ensure your dependents have medical and dental benefits:

- Yourself and your legal spouse or yourself and your same-sex domestic partner
- Yourself and a child or children
- Family

Qualified Medical Child Support Order (QMCSO)
Federal law requires the University to honor a QMCSO issued by a state court as part of a judgment or decree under state domestic relations law or under a law relating to medical child support. A QMCSO relates to and must specify that it arises from medical child support. You will be notified if the Plan Administrator receives a QMCSO that requires you to provide coverage for your dependent identified in the QMCSO.

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

Qualified Medical Child Support Order Defined
A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- The order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- The order states the period to which it applies; and
- If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits
Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.
If You and Your Spouse or Same-Sex Domestic Partner Work for the University

If you and your spouse or same-sex domestic partner work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

- One spouse or same-sex domestic partner makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other spouse or same-sex domestic partner must select "No Coverage."
- Each spouse or same-sex domestic partner can make his or her own medical choice. In this case, all eligible dependents must be covered by employee or the other spouse or same-sex domestic partner.

Enrollment

How to Enroll

Newly Eligible Employee

If you are newly hired, you must enroll for benefits within 31 days of your date of hire. If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will not receive Medical, Vision and Prescription benefit coverage from Columbia University in the City of New York for the remainder of the calendar year.

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 3 weeks of your date of hire, please contact the Columbia Benefits Service Center at 212-851-7000.

Annual Enrollment Opportunities

After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. You will receive notification from the University about this opportunity to change your health plan and the eligible dependents that you want to cover. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

Making Changes to Your Benefits During the Year

After your initial enrollment, or after annual Benefits Open Enrollment, you will be able to change your benefits for the remainder of the calendar year only if you experience a “qualified life status change.” Columbia University in the City of New York healthcare benefits are governed by the Internal Revenue Code (Section 125), which limits when you can make changes to your benefit elections as well as the type of changes you are permitted to make.

Examples of a qualified life status change include:

- Marriage, divorce
- Beginning or end of a same-sex domestic partnership
- Birth, adoption, or placement for adoption
- Death of a dependent
• Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)
• Change in home address that changes your provider network access
• A permanent change in the way you commute to work (applies to the Transit/Parking program)
• Spouse or eligible dependent called to military duty in the United States armed forces.
• Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, you must report it within 31 days of the event on the CU Benefits Enrollment System at www.hr.columbia.edu/benefits. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000. You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

Adding Your Newborn Child
For a newborn’s hospital and medical expenses to be eligible for reimbursement, you must add your child by reporting a qualified life status change online through the CU Benefits enrollment system at www.hr.columbia.edu/benefits within 31 days of the child’s birth. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000. Please remember that because these benefits must comply with IRS regulations, you must provide proper documentation for your change, such as a birth certificate.

Your Cost

Your Cost for Benefit Coverage
You and Columbia University in the City of New York share the cost of your coverage. Each year, the University determines its level of support for benefit coverage for you and your eligible dependents. Costs vary depending on the plan you choose, your annual pay and the number of eligible dependents that you cover.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax “premium” for healthcare coverage is based on these factors:

• The plan you select
• The coverage level you select (individual vs. family, etc.)
• Your Annual Benefits Salary

Your Annual Benefits Salary is calculated as of July 1 each year and is the greater of: (1) your -annual base salary or (2) your year-to-date University income, including certain approved additional and private practice compensation. If you are newly hired, your Annual Benefits Salary is calculated from your compensation at date of hire through the following July 1.
Your Cost for Same-Sex Domestic Partner or Same-Sex Spouse
Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner be deducted from your pay on an after-tax basis unless your domestic or civil union partner is your legal spouse or your federal tax dependent for group health plan purposes. In addition, University contributions toward premiums for covering your domestic partner are taxable to you unless your domestic partner is your legal spouse or your federal tax dependent for group health plan purposes.

Effective October 1, 2013, Officers who are legally married to their same-sex partner, and who live in DC or one of the states that recognize same-sex marriage, are eligible to have their payroll contributions, made to the Columbia medical plan, deducted on a pre-tax basis and not subject to imputed income on the employer-sponsored portion of the costs of medical plan coverage. However, if you live in a state that does not recognize same-sex marriage, you may be subject to state withholding. You must contact the Columbia Benefits Service Center at 212-851-7000 to provide a marriage certificate or to request recognition of your same-sex domestic partner as a federal tax dependent for group health plan purposes.

When Coverage Ends
This section summarizes what happens to your medical coverage when certain events occur including:

- Your employment ends
- You become disabled
- You take a leave of absence-except for those granted through the University (Refer to the Faculty hand book or the Administration Manual. On Leave of Absence)
- You or a covered family member dies

Generally, in situations when Columbia University in the City of New York-provided coverage ends, you and your eligible dependents will be provided with the opportunity to continue coverage for a period of time under COBRA continuation rules. See the section, COBRA Continuation Rights.

When Your Employment Ends
If your employment with the Columbia University in the City of New York ends, your Columbia University in the City of New York-sponsored medical coverage for you and your dependents ends after 21 days or the end of the month – whichever is greater.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Columbia University in the City of New York will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- 21 days after your employment ends or the end of the month – whichever is greater.
• the date the Plan ends;
• the last day of the month you stop making the required “premium” contributions; or
• the last day of the month you are no longer eligible.

Coverage for your eligible Dependents will end on the earliest of:

• the date your coverage ends;
• the last day of the month you stop making the required “premium” contributions; or
• the last day of the month your Dependents no longer qualify as Dependents under this Plan.

However, you may continue the medical coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Columbia University in the City of New York Group Benefits Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.

When Your Employment Ends – Are You Eligible for Retiree Medical Benefits?
If you are separated from your job and you have 10 years of service after age 45, you may be eligible for Retiree Medical coverage sponsored by the University. You must meet any service and age requirement at the time your employment ends. Subsequent attainment of the required age after you leave the Columbia University in the City of New York will count toward the requirement for Columbia University Retiree Medical benefits and eligibility for medical coverage continuation under these provisions.

If you qualify for Columbia University Retiree Medical, you and your covered dependents will remain covered by your selected medical plan until the end of the month in which your employment ends, or if later, the end of the month in which your severance period ends. At that point, you will move into Columbia University Retiree Medical Plan. (However, if you or your eligible dependents are eligible for Medicare due to disability or because you are age 65 or older, Medicare becomes the primary plan for the individual who is Medicare eligible.)

Contact the Columbia Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements.

If You Become Disabled
If you become disabled, your medical coverage can continue based on the type of disability and the length of your disability.

• If you receive salary continuance: Any “premium” contributions you make for Columbia University in the City of New York benefits will continue on a before-tax basis. Your coverage continues without change under the medical plan in effect when your disability began.
• If you receive temporary disability benefits: Any contributions you make for Columbia University in the City of New York benefits will be on an after-tax basis. Coverage continues under the medical plan in effect when your disability began.
• If you receive Long Term Disability benefits: Any “premium” contributions you make for Columbia University in the City of New York will be on an after-tax basis.

Coverage continues for the remainder of the calendar year under the medical plan in effect when your long term disability began. For the next two calendar years, coverage will continue under the Columbia
University in the City of New York program. Medicare health insurance coverage generally becomes available if you have been entitled to Social Security benefits for two years. You must enroll for Medicare when available. For additional information about the need to apply for Medicare, please contact the Columbia University Retiree Service Center at 212-851-7000. For Medicare information, please contact 1-800-Medicare (1-800-633-4227).

If You Take a Leave of Absence
In general, during an approved leave of absence, the coverage in effect before the leave will continue provided that you make the necessary monthly premium payments. However, additional rules apply to military leaves or you may qualify for a protected leave under the Family and Medical Leave Act (see the next page). Please contact the Columbia Benefits Service Center to discuss these rules.

Please note that for certain coverage’s to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The Columbia Benefits Service Center will notify EBPA of your leave of absence status who will calculate the monthly costs for those coverages that will require payment during your leave. You will be charged your regular monthly contribution rate for 6 months. After 6 months of leave, you will be charged the full premium rate, that is, your regular contribution plus the Columbia portion of the premium.

EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)
If you meet the criteria, you are entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under the Columbia University in the City of New York Group Benefits Plan during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make payments. If you don’t timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

Coverage While on Military Duty in the United States Armed Forces
If you enter the United States armed forces, you’ll be offered the opportunity to continue medical coverage for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may elect to either stop or continue your medical coverage during the period of your military absence. If you elect to continue your medical coverage:

- During the first six months of your military absence, you will continue to pay your portion of the cost for the medical coverage you have in effect at the time your military absence began.
- During the seventh through the 24th month of your military absence, you will be directly billed for the cost of the medical coverage you have in effect at the time your military absence began, or, in the following calendar year, based on the coverage and cost in effect under COBRA rules. No further medical coverage will be provided beyond the twenty-fourth month of a military absence.
If you choose not to continue coverage during the period of military service, you’re entitled to have your coverage reinstated provided you timely return to employment with the Company. No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

If You Die
If you die, your surviving dependents who are covered under the Columbia University in the City of New York Group Benefits Plan at the time of your death will receive:

- Medical and prescription coverage for 1 year following the date of your death, free of charge.
- COBRA benefits will then be offered following the one year period of free coverage.

If you were eligible for Retiree Medical benefits at the time of your death, your surviving dependents will be given the choice between COBRA or Retiree Medical coverage as per COBRA regulations and requirements.

If Your Eligible Dependent Dies
If an eligible dependent dies, you can change your medical plan and coverage tier. Any change must be made within 31 days of your dependent’s death; otherwise, you’ll have to wait until the next fall annual Benefits Open Enrollment period.

Other Events Ending Your Coverage
The Plan will provide written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person’s eligibility or status as a Dependent; or
- You commit an act of physical or verbal use that imposes a threat to Columbia University in the City of New York’s staff, the staff of your selected healthcare plan, or a provider.

Uniformed Services Employment and Reemployment Rights Act
An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee’s Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This May include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.
An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee’s absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee’s health coverage and that of the Employee’s eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee’s eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

**When Coverage Ends for Your Dependents**

When you drop coverage for one or more of your covered dependents either during Benefits Open Enrollment or through a Qualified Change in Status, coverage will end as follows:

**Spouse**
The date of your divorce, or commencement of other medical coverage (through spouse’s employer, etc.).

**Same-Sex Domestic Partner**
The date of the dissolution of the partnership or commencement of other medical coverage (through partner’s employer).

**Child**
Coverage ends at the end of the calendar month in which your child turns age 26.

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense.

**COBRA Continuation Rights**

**Continuing Coverage Through COBRA**

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in the Glossary.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University in the City of New York is subject to the provisions of COBRA.

**Continuation Coverage under Federal Law (COBRA)**

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

**Qualifying Events for Continuation Coverage under COBRA**

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events if they cause of loss of coverage under the terms of the Plan.

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
</tbody>
</table>
If Coverage Ends Because of the Following Qualifying Events:

<table>
<thead>
<tr>
<th>Event Description</th>
<th>For Yourself</th>
<th>For Your Spouse or same-sex domestic partner</th>
<th>For Your Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
<td>18 months</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage¹</td>
<td>29 months</td>
<td>29 months</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
<td>N/A</td>
<td>36 months</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
<td>See table below</td>
<td>See table below</td>
</tr>
<tr>
<td>Columbia University in the City of New York files for bankruptcy under Title 11, United States Code,²</td>
<td>36 months</td>
<td>36 months³</td>
<td>36 months³</td>
</tr>
</tbody>
</table>

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). The determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

<table>
<thead>
<tr>
<th>If Dependent Coverage Ends When:</th>
<th>You May Elect COBRA Dependent Coverage For Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become entitled to Medicare and don't experience any additional qualifying events</td>
<td>18 months</td>
</tr>
</tbody>
</table>
If Dependent Coverage Ends When:

<table>
<thead>
<tr>
<th>You May Elect COBRA Dependent Coverage For Up To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires</td>
</tr>
<tr>
<td>You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, you Medicare entitlement would have resulted in loss of Dependent coverage under the Plan</td>
</tr>
</tbody>
</table>

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

**Getting Started**

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under Making Changes to Your Benefits During the Year, in the Enrollment Section.

**Notification Requirements**

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified
Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

**Notification Requirements for Disability Determination**

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Service Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in *Administrative and Legal Information About the Plan: Your ERISA Rights*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

**Trade Act of 2002**

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

**When COBRA Ends**

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
coverage would otherwise terminate under the Plan as described in the beginning of this section. 

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

How Your Medical Plan Works

- Common Terms
- Accessing Providers
- Precertification

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

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

Important Notes

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

Common Terms

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

About Your Aetna Choice POS II HDHP Medical Plan

This Aetna Choice POS II HDHP medical plan provides coverage for a wide range of medical expenses for the treatment of illness or injury. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Aetna Choice POS II HDHP medical plan, you can directly access any physician, hospital or other health care provider (network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through network providers or out-of-network providers.
The plan will pay for covered expenses up to the maximum benefits shown in this Booklet. Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the What the Plan Covers, Exclusions, Limitations and Schedule of Benefits sections to determine if medical services are covered, excluded or limited.

This Aetna Choice POS II HDHP medical plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This Aetna Choice POS II HDHP medical plan is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Your deductibles, copayments, and coinsurance will generally be lower when you use participating network providers and facilities. Your network provider may practice out of multiple locations; please confirm with Aetna to ensure that both the provider and the facility are in-network.

You also have the choice to access licensed providers, hospitals and facilities outside the network for covered benefits. Your out-of-pocket costs will generally be higher. Deductibles, copayments, and coinsurance are usually higher when you utilize out-of-network providers. Out-of-network providers have not agreed to accept the negotiated charge and may balance bill you for charges over the amount Aetna pays under the plan. You will be responsible for any charges in excess of 60% of the 190% of the Medicare Maximum Allowable Charge.

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

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

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

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

To better understand the choices that you have with your Aetna Choice POS II HDHP medical plan, please carefully review the following information.
**How Your Aetna Choice POS II HDHP Medical Plan Works**

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

**Accessing Network providers and Benefits**

- You may select a PCP or other direct access network provider from the network provider directory or by logging on to Aetna’s website at www.Aetna.com. You can search Aetna’s online directory, DocFind, for names and locations of physicians and other health care providers and facilities. You can change your PCP at any time.

- If a service you need is covered under the plan but not available from a network provider or hospital in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.

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

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

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

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

- You will need to satisfy any applicable deductibles before the plan will begin to pay benefits.

- For certain types of services and supplies, you will be responsible for any copayments shown in the Schedule of Benefits.

- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.

- Once you satisfy the maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to the Schedule of Benefits section for information on what expenses do not apply. Refer to your Schedule of Benefits for the specific maximum out-of-pocket limit, amounts that apply to your plan.
• The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers or Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers or Schedule of Benefits* sections.

• You may be billed for any **deductible**, **copayment**, or **payment percentage** amounts, or any non-covered expenses that you incur.

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

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

• You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.

• After you satisfy any applicable **deductible**, you will be responsible for any applicable **payment percentage** for **covered expenses** that you incur. You will be responsible for your **payment percentage** up to the **maximum out-of-pocket limit** applicable to your plan.

• Your **payment percentage** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

• Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Getting Started: Common Terms* section for information on what expenses do not apply. Refer to your *Schedule of Benefits* for specific dollar amounts.

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

### Understanding Precertification

**Precertification (Preauthorization)**

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

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

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

**Important Note**

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.
The Precertification Process
Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

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

<table>
<thead>
<tr>
<th>Precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made: For non-emergency admissions:</th>
<th>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For an emergency outpatient medical condition:</td>
<td>You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.</td>
</tr>
<tr>
<td>For an emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>For an urgent admission:</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.</td>
</tr>
<tr>
<td>For outpatient non-emergency medical services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
<tr>
<td>For prenatal care and delivery:</td>
<td>As soon as possible after the attending physician confirms pregnancy and again within 48 hours of the birth or as soon thereafter as possible. No benefit reduction will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.</td>
</tr>
</tbody>
</table>

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

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your pre-certified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.
If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna’s decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the Claim Procedures/Complaints and Appeals /Dispute Resolution section of this Booklet.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care
- Intensive Outpatient Programs for mental disorders and substance abuse
- Amytal interview
- Applied Behavioral Analysis
- Biofeedback
- Electroconvulsive therapy
- Neuropsychological
- Psychiatric home care services
- Psychological testing

How Failure to Pre-certify Affects Your Benefits

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

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

How Your Benefits for Inpatient and Outpatient Care, Procedures and Treatment are Affected

The chart below illustrates the effect on your benefits if necessary precertification for outpatient or inpatient services, procedures and treatments is not obtained.
If precertification is:  

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<th>then the expenses are:</th>
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<tbody>
<tr>
<td>requested and approved by Aetna</td>
<td>covered.</td>
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<tr>
<td>requested and denied</td>
<td>not covered, may be appealed.</td>
</tr>
<tr>
<td>not requested, but would have been covered if requested</td>
<td>covered after a precertification benefit reduction is applied.</td>
</tr>
<tr>
<td>not requested, would not have been covered if requested</td>
<td>not covered, may be appealed.</td>
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It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment percentage or maximum out-of-pocket limit.

**Emergency and Urgent Care**

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

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

**In Case of a Medical Emergency**

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

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

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition (one that does not meet the criteria above), the plan will not cover the expenses you incur. Please refer to the Schedule of Benefits for specific details about the plan.

* Refer to the Schedule of Benefits section for the amount of precertification benefit reduction that applies to your plan.
Coverage for Emergency Medical Conditions
The plan will pay for hospital services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physicians’ services;
- Hospital nursing staff services; and
- Radiologists and pathologists services within Plan limits

Please contact a physician after receiving treatment of an emergency medical condition.

Important Reminder
If you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition
An urgent condition is a sudden illness, injury or condition that:

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

Call your physician if you think you need urgent care. Physicians usually provide coverage 24 hours a day, including weekends and holidays for urgent care. You may contact any physician or urgent care provider, for an urgent care condition if you cannot reach your physician.

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

Coverage for an Urgent Condition
The plan will pay for the services of an urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of urgent care facilities;
- Physician services;
- Nursing services; and
- Staff radiologists and pathologists services within Plan limits
Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

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

For coverage purposes, follow-up care is treated as an expense for routine illness or injury. If you access a hospital emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to your Schedule of Benefits for cost sharing information applicable to your plan.

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

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

Important Notice

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

Requirements For Coverage

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

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

2. The service or supply must be provided while coverage is in effect. See the Eligibility, When Coverage Ends and COBRA Continuation Rights sections for details on when coverage begins and ends.

3. The service or supply must be medically necessary. To meet this requirement, the medical services or supply must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
   a. In accordance with generally accepted standards of medical practice;
   b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
   c. Not primarily for the convenience of the patient, physician or other health care provider;
   d. And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.
For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

**Important Note**

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

**What the Plan Covers**

- Wellness
- Physician Services
- Hospital Expenses
- Other Medical Expenses

**Aetna Choice POS II HDHP**

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

**Wellness**

This section on Wellness describes the covered expenses for services and supplies provided when you are well. Refer to the Schedule of Benefits for the frequency limits that apply to these services, if not shown below.

**Routine Physical Exams**

Covered expenses include charges made by your physician for routine physical exams. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
  - Testing for:
    - Tuberculosis
    - Diphtheria, pertussis, tetanus (DPT)
    - Hepatitis A & B
    - Human papillomavirus (HPV)
    - Influenza
    - Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chicken pox).

Covered expenses for children from birth through age 18 also include:

- An initial hospital check-up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

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

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

Note that blood work and certain tests prescribed by your physician during your annual physical may not be considered preventive. Call Aetna for confirmation.

Important Reminder
Refer to the Schedule of Benefits for details about any applicable deductibles, payment percentage, benefit maximums and frequency and age limits for physical exams.

Routine Cancer Screenings
Covered expenses include charges incurred for routine cancer screening as follows:

- 1 mammogram for covered females age 35-39;
- 1 mammogram every 12 months for covered females age 40 and over;
- 1 Pap test every 12 months;
- 1 gynecological exam every 12 months;
- 1 fecal occult blood test every 12 months; and
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test every 12 months for covered males age 40 and older.

The following tests are covered expenses if you are age 50 and older when recommended by your physician:

- 1 Sigmoidoscopy every 5 years for persons at average risk; or
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; or
- 1 Colonoscopy every 5 years for persons at average risk for colorectal cancer, no age limit for those with diagnosis of family history.

Family Planning Services
Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury. Refer to the Schedule of Benefits for the frequency limits that apply to these services, if not specified below.

Covered expenses include charges for family planning services, including:
• Voluntary sterilization.
• Voluntary termination of pregnancy.

The plan does not cover the reversal of voluntary sterilization procedures, including related follow-up care.

**Contraceptive Coverage**
Both pharmaceutical methods and in-office/surgical methods of contraception are covered at no cost, provided the services are obtained in-network.

**Pharmaceutical Contraceptives**
The Columbia prescription drug plan covers female contraceptive methods with no copay, provided it is generic or single-source brand contraception:

• Approved by the Food and Drug Administration (FDA),
• Filled at an in-network pharmacy, or
• Filled by mail-order.

**In-Office/Surgical Contraception**
The Columbia healthcare plans cover the following in-network services at no cost to you:

• Two visits a year for patient education and counseling on contraceptives
• Administration of certain contraceptives, such as the insertion of IUDs or injections
• Women’s sterilization procedures

Also see section on pregnancy and infertility related expenses on a later page.

**Vision Care Services**

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

• *Routine* eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 24 consecutive month period.

**Limitations**
Unless specified above, the benefit plan does not cover charges for a service or supply furnished by other than a network provider.

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

**Vision Care Supplies**
You and each of your covered dependents are eligible for covered expenses for prescription lenses and frames, or prescription contact lenses up to the vision supply maximum listed on your Schedule of Benefits.

**Important Reminder**
Refer to the Schedule of Benefits for information about any applicable maximums that apply to vision care supplies.
Hearing Exam

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

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

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

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

Physician Services

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

- Immunizations for infectious disease,
- Allergy testing and allergy injections; and
- Charges made by the physician for supplies, radiological services, x-rays, and tests provided by the physician.

Surgery

Covered expenses include charges made by a physician for:

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

Limitations

Multiple Surgical Procedures on the Same Day
Covered expenses for multiple surgical procedures are limited as follows:

- Covered expenses for a secondary procedure are limited to 50% of the covered expense that would otherwise be considered for the secondary procedure had it been performed during a separate operative session
- Covered expenses for any subsequent procedure performed in addition to a secondary procedure are limited to 25% of the covered expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.
The medical insurance carrier uses National Physician Fee Schedule (NPFS) developed by the Centers for Medicare and Medicaid Services (CMS) to determine which procedures are subject to the multiple procedure reductions.

If you are having surgery on an out-of-network basis that may involve multiple procedures, you can get information on any limitations that may be applied in advance. Get a statement of all the fees you will be billed and the corresponding billing codes. Call your medical insurance carrier and request a pre-treatment review.

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

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

Alternatives to Physician Office Visits

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

- Unscheduled, non-emergency illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic’s license.

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

Room and Board
Covered expenses include charges for room and board provided at a hospital during your stay.

Private room charges that exceed the hospital’s semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:

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

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

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

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

Outpatient Hospital Expenses

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

Important Reminder
The plan will only pay for nursing services provided by the hospital as part of its charge.

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

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

In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay. Covered expenses for these charges are payable at the out-of-network benefit level if the provider has not contracted with Aetna, even if the facility is in the Aetna network.

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

Coverage for Emergency Medical Conditions

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

The emergency care benefit covers:

• Use of emergency room facilities;
• Emergency room physicians services;
• Hospital nursing staff services; and
• Radiologists and pathologists services within Plan limits

Please contact your physician after receiving treatment for an emergency medical condition.
Important Reminder
If you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room.

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

Your coverage includes:
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services within Plan limits

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

Alternatives to Hospital Stays
Outpatient Surgery and Physician Surgical Services
Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:
- An office-based surgical facility of a physician or dentist;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:
- The surgery can be performed adequately and safely only in a surgery center or hospital and
- The surgery is not normally performed in a physician’s or dentist’s office.

Important Note
Benefits for surgery services performed in a physician’s or dentist’s office are described under Physician Services benefits in the previous section.

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

Limitations
Not covered under this plan are charges made for:
• The services of a **physician** or **other health care** provider who renders technical assistance to the operating **physician**.
• A stay in a hospital.
• Facility charges for office based surgery.

**Birthing Center**

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

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

**Limitations**

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

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

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

**Home Health Care**

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

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

**Covered expenses** include only the following:

• **Skilled nursing services** that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a **hospital** or **skilled nursing facility** after an inpatient **stay**, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous **skilled nursing services**. However, these services must be provided for within 10 days of discharge.
• Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
• Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.

Benefits for **home health care** visits are payable up to the **home health care** maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.
This maximum will not apply to care given by an R.N. or L.P.N. when:

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

When the above criteria are not met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

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

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

**Limitations**

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

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

**Important Reminders**

- The plan does not cover custodial care, even if care is provided by a nursing professional and family member or other caretakers cannot provide the necessary care.
- Home health care needs to be pre-certified by Aetna. Refer to How the Plan Works for details about precertification.

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

**Private Duty Nursing**

Covered expenses include private duty nursing provided by a R.N. or L.P.N. if the person’s condition requires skilled nursing care and visiting nursing care is not adequate. However, covered expenses will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.
The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or emergency medical condition by a physician;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient stay; or
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

**Limitations**

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

- Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.

- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility, provided the care can adequately be provided by the facility’s general nursing staff, if it were fully staffed.

**Skilled Nursing Facility**

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

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

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

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

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

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

Hospice Care
Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses
The charges made by a hospital, hospice or skilled nursing facility for:

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

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

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

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:
• A physician for a consultation or case management;
• A physical or occupational therapist;
• A home health care agency for:
  ♦  Physical and occupational therapy;
  ♦  Part time or intermittent home health aide services for your care up to eight hours a day;
  ♦  Medical supplies;
  ♦  Prescription drugs;
  ♦  Psychological counseling; and
  ♦  Dietary counseling.

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

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

**Important Reminders**
Refer to the Schedule of Benefits for details about hospice care maximums.
Inpatient hospice care and home health care must be pre-certified by Aetna. Refer to How the Plan Works for details about precertification.

**Other Covered Health Care Expenses**

**Acupuncture**
The plan covers charges made for acupuncture services provided by a physician, if the service is performed:

• As a form of anesthesia in connection with a covered surgical procedure.

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

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

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

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

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

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

• If an ambulance service is not required by your physical condition; or
• If the type of ambulance service provided is not required for your physical condition; or
• By any form of transportation other than a professional ambulance service.

Cranial Banding
Cranial banding is covered in certain circumstances. To receive coverage, prior authorization from Aetna is required. Cranial remodeling bands (or helmets) as medically necessary apparatus for treatment of moderate to severe positional head deformities associated with premature birth, restrictive intrauterine positioning, cervical abnormalities, birth trauma, torticollis (shortening of the sternocleidomastoid muscle) and sleeping positions in children when banding is initiated at 4 to 12 months of age. Call the toll-free number on the back of your ID card to request authorization.

Diagnostic and Preoperative Testing

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

• C.A.T. scans;
• Magnetic Resonance Imaging (MRI);
• Positron Emission Tomography (PET) Scans; and
• Any other outpatient diagnostic imaging service costing over $500.
Complex Imaging Expenses for preoperative testing will be payable under this benefit.

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

**Outpatient Diagnostic Lab Work and Radiological Services**

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

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

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

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

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

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

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

**Durable Medical and Surgical Equipment (DME)**

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

- The initial purchase of **DME** if:
  - Long term care is planned; and
  - The equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment.
• Maintenance and repairs needed due to misuse or abuse are not covered.

• Replacement of purchased equipment if:
  ♦ The replacement is needed because of a change in your physical condition; and
  ♦ It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

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

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

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

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

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

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

If the mother is discharged earlier, the plan will pay for one post-delivery home visits by a health care provider.

A deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Covered expenses for a birthing center are described under Alternatives to Hospital Care.

Note: Covered expenses also include services and supplies provided for circumcision.

Prenatal Care and Breastfeeding
Routine in-network prenatal visits are covered with the normal cost share as defined by the plan for delivery, postpartum care, ultrasounds or other maternity procedures, specialist visits and certain lab tests.

The following services and equipment are covered at 100%:

• Six visits with a lactation consultant
• Rental of a hospital-grade electric breast pump if your baby is detained in the hospital
• Purchase of certain standard electric breast pumps within 60 days of a birth, once every three years
• Purchase of certain standard manual breast pumps within 12 months of birth, if you have not received an electric or manual breast pump within the last three years
• Another set of breast pump supplies, if you are pregnant before you are eligible for a new pump.
• Before buying a pump, please check the member website or call Aetna member services to learn more details and to find a participating breast pump supplier.

Additional Services for Pregnant Women
The following services are covered at 100%:
• Anemia screening
• Bacteriuria, urinary tract or other infection screenings
• RH incompatibility screening, with follow-up testing for women at higher risk
• Hepatitis B
• Counseling on tobacco use
• Breastfeeding interventions to support and promote breastfeeding after delivery
• Diabetes screening

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

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

Covered expenses also include replacement of a prosthetic device if:
• The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
• It is likely to cost less to buy a new one than to repair the existing one; or
• The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:
• An artificial arm, leg, hip, knee or eye;
• Eye lens;
• An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
• A breast implant after a mastectomy;
• Ostomy supplies, urinary catheters and external urinary collection devices;
• Speech generating device;
• A cardiac pacemaker and pacemaker defibrillators;
• A durable brace that is custom made for and fitted for you; and
• Orthotics.

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

• Trusses, corsets, and other support items or
• any item listed in the *Exclusions* section.

**Short-Term Rehabilitation Therapy Services**

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

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

Charges for the following short term rehabilitation expenses are covered:

**Cardiac and Pulmonary Rehabilitation Benefits**

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

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

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

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

- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one’s thoughts with spoken words.

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

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

The therapy should follow a specific treatment plan that:

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

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

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

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

**Reconstructive or Cosmetic Surgery and Supplies**
Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive services and supplies, including:
Surgery needed to improve a significant functional impairment of a body part.

Surgery to correct the result of an accident, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 26.

Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

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

Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when

- the defect results in severe facial disfigurement, or
- the defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

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

Important Notice

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

Specialized Care

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

Covered expenses include charges made on an outpatient basis for infusion therapy by:

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

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses.
The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

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

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

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

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled nursing facility Benefits sections of this Booklet.

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

**Important Reminder**
Refer to the Schedule of Benefits for details on any applicable deductible, payment percentage and maximum benefit limits.

**Treatment of Infertility**

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

**Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses**
To be an eligible covered female for benefits you must be covered under this Booklet as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an illness or injury, covered expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:

- A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or a network infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
• The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
• A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Booklet.

Comprehensive Infertility Services Benefits
If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by a network infertility specialist upon pre-authorization by Aetna, subject to all the exclusions and limitations of this Booklet:
• Ovulation induction with menotropins Intrauterine insemination).
• Intrauterine insemination

Advanced Reproductive Technology (ART) Benefits
ART is defined as:
• In vitro fertilization (IVF);
• Zygote intrafallopian transfer (ZIFT);
• Gamete intra-fallopian transfer (GIFT);
• Cryopreserved embryo transfers;
• Intracytoplasmic sperm injection (ICSI); or ovum microsurgery

ART services for procedures that are covered expenses under this Booklet.

Eligibility for ART Benefits
To be eligible for ART benefits under this Booklet, you must meet the requirements above and:
• First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected.
• Be referred by your physician to Aetna's infertility case management unit;
• Obtain pre-authorization from Aetna's infertility case management unit for ART services by a network ART specialist.

ART Services are available only from the network ART specialists when you have been issued pre-authorization by Aetna's infertility case management unit. Treatment received from an out-of-network provider or without a pre-authorization will not be covered and you will be responsible for payment of all services. Covered expenses for ART services are only provided for network care.

Covered ART Benefits
The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the Booklet:
• Up to 3 cycles and subject to the maximum benefit, if any, shown in the Schedule of Benefits section of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received provided or administered by Aetna or any affiliated company of Aetna while covered under an Aetna plan, or any other health benefits plan, or where no plan coverage was provided) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the Schedule of Benefits section while covered under an Aetna plan;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this Booklet.

**Exclusions and Limitations**

Unless otherwise specified above, the following charges will not be payable as covered expenses under this Booklet:

- **ART** services for a female attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;
- **ART** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- Any services or supplies provided without pre-authorization from Aetna’s infertility case management unit;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not infertile;
- Services and supplies furnished by an out-of-network provider.

**Important Note**

Treatment of Infertility must be pre-authorized by Aetna. Treatment received without pre-authorization will not be covered. You will be responsible for full payment of the services.

Refer to the Schedule of Benefits for details about the maximums that apply to infertility services. The lifetime maximums that apply to infertility services apply differently than other lifetime maximums under the plan.
Spinal Manipulation Treatment

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

Your benefits are subject to the maximum shown in the Schedule of Benefits. However, this maximum does not apply to expenses incurred:

- During your hospital stay;
- For treatment of scoliosis;
- For fracture care; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating physician.

Temporomandibular Joint (TMJ) Disorder Treatment

The plan covers charges made by a physician, hospital or surgery center for the diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder as follows:

Arthrocentesis for temporomandibular joint (TMJ) disorder as medically necessary when the following criterion is met:

- Clinical examination and/or diagnostic imaging indicate the presence of hypomobility of the temporomandibular joint and symptoms persist despite at least six months of noninvasive therapy such as physical therapy and the use of intra-oral appliances.

Arthroscopy for TMJ disorder as medically necessary when BOTH of the following criteria are met:

- Pain or significant hypomobility persists despite at least six months of scientifically recognized noninvasive therapies such as pharmacologic pain control, physical therapy and the use of intra-oral appliances.
- Clinical examination and diagnostic imaging indicate the presence of joint pathology that requires internal structural modification.

Arthrotomy for TMJ disorder as medically necessary when the criteria for arthroscopy listed above are met but arthroscopy is not technically feasible, appropriate, or has previously failed to resolve the problem being treated.

Arthrotomy with total prosthetic joint replacement as medically necessary using The TMJ Concepts Patient-Fitted TMJ Reconstruction Prosthesis for TMJ disorder when ANY of the following criteria are met, and the indication for surgery is confirmed by magnetic resonance imaging (MRI), computed tomography (CT) or corrected tomogram:

- inflammatory arthritis involving the TMJ not responsive to other modalities of treatment
- recurrent fibrosis and/or bony ankylosis not responsive to other modalities of treatment
- failed tissue graft
- failed alloplastic joint reconstruction
- loss of vertical mandibular condylar height due to bone resorption, trauma, developmental abnormality or pathologic lesion
Always excludes appliances and orthodontic treatment. Subject to medical necessity.

Transplant Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transgender Reassignment Services:
Covered expenses include charges in connection with a medically necessary Transgender Reassignment Surgery as long you or a covered dependent have obtained precertification from Aetna and have met the following conditions:
• You or your dependent is at least 18 years old; and
• You or your dependent have met criteria for the diagnosis of "true" transsexualism including:
  ♦ A life-long sense of belonging to the opposite gender and of having been born into the wrong gender, often since childhood; and
  ♦ A sense of estrangement from one's own body, so that any evidence of one's own biological gender is regarded as repugnant; and
  ♦ A desire to make his or her body as congruent as possible with the preferred gender through surgery and hormone treatment; and
  ♦ A stable transgender orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other gender for at least 2 years, (i.e. not limited to periods of stress); and
  ♦ There is no sexual arousal from cross-dressing; and
  ♦ There is an absence of physical inter-sex of genetic abnormality; and
  ♦ This is not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; and
• You or your dependent must have completed a recognized program of transgender identity treatment as evidenced by all of the following:
  ◆ Has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; and
  ◆ Unless medically contraindicated, has received at least 12 months of continuous hormonal sex change therapy recommended by a behavioral health provider and carried out by an endocrinologist (which can be simultaneous with the real-life experience); and
  ◆ A behavioral health provider who has been acquainted with you [or your dependent] for at least 18 months recommends gender change surgery documented in the form of a written comprehensive evaluation; and
  ◆ For genital surgical gender change, a second concurring recommendation by another qualified behavioral health provider must be documented in the form of a written expert opinion as long as one of the two behavioral health providers possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.); and
  ◆ Psychotherapy is not an absolute requirement for surgery unless the behavioral health provider's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); and
  ◆ For genital surgical gender change, you or your dependent has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital surgical gender change includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital change); and
  ◆ You or your dependent have demonstrated an understanding of the proposed male-to-female or female-to-male gender reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and postsurgical rehabilitation requirements of the planned surgery.

The covered person has obtained precertification from Aetna.

• Covered expenses include:
  ◆ Charges made by a physician for:
  ◆ Performing the surgical procedure; and
  ◆ Pre-operative and post-operative hospital and office visits.
  ◆ Charges made by a hospital for inpatient and outpatient services (including outpatient surgery).

Room and board charges in excess of the hospital’s semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

  ◆ Charges made by a Skilled Nursing Facility for inpatient services and supplies. Room and board charges in excess of the hospital’s semi-private rate will not be covered.
  ◆ Charges made for the administration of anesthetics.
  ◆ Charges for outpatient diagnostic laboratory and x-rays.
  ◆ Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

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Important Reminders
No payment will be made for any covered expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Schedule of Benefits for details about deductibles, coinsurance or benefit maximums.

Limitations:
Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, liposuction of the waist, reduction thyroid chondroplasty, laryngoplasty or shortening of the vocal cords, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction.

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

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

Covered expenses include one morbid obesity surgical procedure, within a two-year period, beginning with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

But only when you have a:

- Body mass index (BMI) exceeding 40; or
- BMI greater than 35 in conjunction with any of the following co-morbidities any one of which is aggravated by the obesity:
  - Coronary heart disease;
  - Type 2 diabetes mellitus;
  - Clinically significant obstructive sleep apnea; or
  - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management.

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

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

Important Reminder
Refer to the Schedule of Benefits for information about any applicable benefit maximums that apply to morbid obesity treatment.
Alcoholism, Substance Use and Mental Disorders Treatment

Covered expenses include charges made for the treatment of alcoholism, substance use and mental disorders by behavioral health providers.

Important Notice
Not all types of services are covered. For example, wilderness treatment, educational services and certain types of therapies are not covered. See the Exclusions section for more information.

Treatment of Mental Disorders
Covered expenses include charges made for the treatment of other mental disorders by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

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

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

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

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

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

Important Reminder
Inpatient care must be pre-certified by Aetna. Refer to the How the Plan Works section for more information about precertification.

Alcoholism and Substance Use Disorder
Covered expenses include charges made for the treatment of alcoholism and substance use disorder by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:
- There is a program of therapy prescribed and supervised by a behavioral health provider.
- The program of therapy includes either:
  - A follow up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance use disorder.

**Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)**

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

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

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

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

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

1. Natural teeth damaged, lost, or removed due to injury; or
2. Other body tissues of the mouth fractured or cut due to injury.

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

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

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

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

**Covered expenses** include charges made for limited services and supplies related to the treatment of teeth, gums, and jaws and their supporting structures, muscles and nerves as follows:

- **Accidental injuries** and other trauma. The plan covers oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state, but only if the services take place no later than 24 months after the injury.

Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
If a child needs oral surgery as the result of **accidental injury** or trauma, surgery may be postponed until a certain level of growth has been achieved.

*Note: Trauma which occurs as a result of biting or chewing is not considered accidental injury, even if it is unplanned or unexpected.*

**Pathology**
- The plan covers removal of tumors and cysts requiring pathological examination.

**Radiation Treatment**
- The plan covers fluoride treatment, removal of teeth and hyperbaric oxygen therapy in connection with covered radiation therapy.

**Anatomical Defects**
- The plan covers oral surgery and related dental services to correct a gross anatomical defect present at birth that results in significant functional impairment of a body part, if the services or supplies will improve function.

**Related Dental Services Are Limited To:**
- The first placement of a permanent crown or cap to repair a broken tooth;
- The first placement of dentures or bridgework to replace lost teeth; and
- Orthodontic therapy to preposition teeth.

Dental implants are not covered.

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

*Important Note:*
You have medical and vision coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific vision coverage. Those additional exclusions are listed separately under the *What the Plan Covers* section for each of these benefits.

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

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

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this *Booklet*. 
Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

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

Artificial organs: Any device intended to perform the function of a body organ.

Behavioral Health Services:

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

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

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

Charges made in advance of services rendered are not covered. These are also known as “Advance Bills” or “Pre-Bills” and no reimbursement will be made by the Plan for these types of provider bills. Only charges for services rendered will be considered for reimbursement.

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

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

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

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

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

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

Custodial Care

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

• services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
• dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
• non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

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

Drugs, medications and supplies:

• Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
• Any services related to the dispensing, injection or application of a drug;
• Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States.
• Needles, syringes and other injectable aids, except as covered for diabetic supplies;
• Drugs related to the treatment of non-covered expenses;
• Performance enhancing steroids;
• Implantable drugs and associated devices;
• Injectable drugs if an alternative oral drug is available;
• Outpatient prescription drugs;
• Self-injective prescription drugs and medications;
• Any prescription drugs, injectable, or medications or supplies provided by the contract holder or through a third party vendor contract with the contract holder;
• Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
• Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

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

Examinations:

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

Experimental or investigational drugs, devices, treatments or procedures,

Facility charges for care services or supplies provided in:

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

Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including:

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

• Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace.

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

Hearing:

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

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

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

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

Home uterine activity monitoring.

Jaw Joint Disorder Treatment: Charges involving treatment for painful condition of the jaw joint itself such as TMJ dysfunction except as specifically described in What the Plan Covers Section.

Infertility: except as specifically described in the What the Plan Covers Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
• Drugs related to the treatment of non-covered benefits;
• Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
• Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
• Procedures, services and supplies to reverse voluntary sterilization
• Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
• The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
• Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
• Home ovulation prediction kits or home pregnancy tests; and
• Ovulation induction and intrauterine insemination services if you are not fertile.

Maintenance care

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

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

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

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

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

Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as specifically described in the Private Duty Nursing provision in the What the Plan Covers Section.

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

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

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

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

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

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

Services that are not covered under this Booklet.

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

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

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body.
Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

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

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

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

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

Transplant: The transplant coverage does not include charges for:

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

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

Vision-related services and supplies, except as described in the What the Plan Covers section. The plan does not cover:
• Anti-reflective coatings;
• Special supplies such as non-prescription sunglasses and subnormal vision aids;
• Vision service or supply which does not meet professionally accepted standards;
• Tinting of eyeglass lenses;
• Special vision procedures, such as orthoptics, vision therapy or vision training;
• Eye exams during your stay in a hospital or other facility for health care;
• Eye exams for contact lenses or their fitting;
• Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
• Replacement of lenses or frames that are lost or stolen or broken;
• Acuity tests;
• Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
• Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as provided by this Booklet, including but not limited to:
• Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
• Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
• Counseling, coaching, training, hypnosis or other forms of therapy; and
• Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.
Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause.

Your Aetna Vision Expense Plan
It is important that you have the information and useful resources to help you get the most out of your Aetna vision expense plan. This section explains:

• Definitions you need to know;
• How to access services, including procedures you need to follow;
• What services and supplies are covered and what limits may apply;
• What services and supplies are not covered by the plan;
• How you share the cost of your covered services and supplies; and
• Other important information such as general administration of the plan.

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

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

About the Basic Vision Expense Plan
Using the Plan
The Basic Vision Expense plan will pay for covered expenses, up to the maximums shown in the Schedule of Benefits.

• You can directly access physicians and other vision care providers of your choice for covered vision services and supplies under the plan.
• You may have to pay the provider or facility full charges and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of
covered expenses you paid directly to the provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.

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

Cost Sharing

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

- You must satisfy any deductibles before the plan begins to pay benefits.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur.
- Your payment percentage will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge.
- The plan will pay for covered expenses, up to the maximums shown in the What the Plan Covers or Schedule of Benefits sections. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers or Schedule of Benefits sections.

**Basic Vision Expense Plan**

What the Plan Covers
This plan covers charges for certain vision care supplies described below. The plan limits coverage to a maximum benefit amount per benefit period. Refer to your Schedule of Benefits to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum, listed in the Schedule of Benefits.

**Vision Supplies**
This plan covers charges for lenses and frames, or prescription contact lenses when prescribed by a legally qualified ophthalmologist or optometrist, up to the Vision Supply Maximum, per benefit period listed in your Schedule of Benefits.

**Limitations**
All covered expenses are subject to the vision expense exclusions in this Booklet and are subject to the deductible(s), copayments or payment percentage listed in the Schedule of Benefits, if any.

Coverage is subject to the exclusions listed in the Vision Care Exclusions section of this Booklet.

Benefits for Vision Care Supplies After Your Coverage Terminates
If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before you coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription.
Coverage is subject to the benefit maximums described above and in your Schedule of Benefits.

**Vision Plan Exclusions**

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician. The plan covers only those services and supplies that are included in the What the Plan Covers section. Charges made for the following are not covered. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These vision exclusions are in addition to the exclusions listed under your medical coverage.

- Any charges in excess of the benefit, dollar, or supply limits stated in this *Booklet*.
- Any exams given during your stay in a hospital or other facility for medical care.
- An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.
- Drugs or medicines.
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- For an eye exam which:
  - Is required by an employer as a condition of employment; or
  - An employer is required to provide under a labor agreement; or
  - Is required by any law of a government.
- Prescriptions or over-the-counter drugs or medicines.
- Special vision procedures, such as orthoptics, vision therapy or vision training.
- Vision service or supply which does not meet professionally accepted standards.
- Anti-reflective coatings.
- Tinting of eyeglass lenses.
- Duplicate or spare eyeglasses or lenses or frames for them.
- Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.
- Replacement of lost, stolen or broken prescription lenses or frames.
- Special supplies such as non-prescription sunglasses and subnormal vision aids.
- Vision services that are covered in whole or in part:
  - Under any other part of this plan; or
  - Under any other plan of group benefits provided by the contractholder; or
  - Under any workers’ compensation law or any other law of like purpose.

**Schedule of Benefits**

Employer: Columbia University in the City of New York

ASA: 619362
Effective Date: January 1, 2014

For: Aetna Choice POS II HDHP Benefits

This is an ERISA plan, and you have certain rights under this plan. Please see the ERISA Rights section for additional information.

High Deductible Health Plan (HDHP)

*High Deductible Health Plan that can be paired with a tax-favored Health Savings Account (HSA)*

- This option offers the lowest monthly contributions of your healthcare plan choices – while providing certain tax advantages when you use an HSA.
- In exchange for lower contributions, the HDHP has the highest deductibles and highest out-of-pocket maximums.
- Eligible in-network preventive care is that follows age and gender guidelines is covered at 100%.
- Prescription drugs are integrated under the HDHP. This means you must meet the deductible before you start to receive reimbursement for prescription drugs. However, prescriptions that are designated “preventive” under federal guidelines are not subject to the deductible.
- *Aetna* is the insurance carrier for the HDHP. The network of doctors and hospitals is the same as for the other *Aetna* POS Plans.

**Features of Your Aetna Choice POS II HDHP**

- For non-preventive care – and non-preventive drugs – you pay for your expenses until you reach your deductible: $1,250 for individual coverage or $2,500 for family coverage. If one or more family members are covered in addition to yourself, you reach the family deductible when total expenses reach $2,500, no matter how the expenses are spread out across the family. The entire $2,500 family deductible must be met, even if only one family member has claims.
- After you reach the deductible for the covered person, any additional medical expenses are shared between the University and you as “coinsurance.” The University’s coinsurance is 90% - Columbia pays 90% of the additional in-network services. Your coinsurance is 10%.
- When your coinsurance plus deductible(s) reach the out-of-pocket maximum, the Plan pay 100% of your remaining covered medical services for the rest of the calendar year. The “out-of-pocket maximum” for in-network expenses is $2,750 for individual coverage or $5,500 for family coverage. For family coverage, the entire $5,500 out-of-pocket maximum for in-network expenses must be met, even if only one family member has claims.

**Prescription Drug Coverage**

Prescription drug coverage is integrated into the HDHP. This means you must pay for your prescription drugs until you meet your deductible. However, prescription drugs that are categorized as “preventive” under federal guidelines are not subject to the deductible, but those categorized as “non-preventive” are.
Drugs in certain categories will be covered as if you had already met your network deductible, so you are only responsible for paying the appropriate copay. This list provides the therapeutic classes of prescription drugs, and the conditions for which drugs may be prescribed, that are considered “preventive” under federal guidelines. This list is subject to change:

- Anticoagulants
- Antihypertensive Agents (High Blood Pressure)
- Asthma/COPD
- Cholesterol Lowering Agents
- Diabetes
- Heart Disease
- Hepatitis C
- Immunosuppressant Agents
- Mental Health Agents
- Prenatal Vitamins
- Thyroid Disease
- Osteoporosis
- Contraceptives

*Note: Non-preventive prescription drug copays and the deductible accumulate to the network out-of-pocket maximum.*

### Aetna Choice POS II HDHP Schedule

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible*</td>
<td>$1,250</td>
<td>$2,500 Per person</td>
</tr>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Deductible*</td>
<td>$2,500</td>
<td>$2,500 Per person</td>
</tr>
<tr>
<td>Employee Plus One or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Plus Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Plan Payment Limit excludes plan copayment and precertification penalties

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Plan Payment Limit</td>
<td>$2,750</td>
<td>$6,000</td>
</tr>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Plan Payment Limit</td>
<td>$5,500</td>
<td>$12,000</td>
</tr>
<tr>
<td>Employee Plus One or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Plus Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Lifetime Maximum Benefit per person**: Unlimited Unlimited
Plan Payment limit excludes plan precertification penalties, comprehensive infertility expenses and ART, copays for prescription drugs on the preventive list, and charges in excess of 190% of the Medicare Maximum Allowable Charge.

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

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

All Out-of-Network Covered Expenses are subject to 190% of the Medicare Maximum Allowable Charges.

For all out-of-network claims, reimbursement is limited to 190% of the Medicare Maximum Allowable Charge. This reimbursement maximum is significantly less than Reasonable & Customary limits – it may be as low as 20% of the billed amount. If you use an out-of-network provider, your claim reimbursement will be based on the 190% of Medicare’s Maximum Allowable Charge, and your deductible of $2,500 and coinsurance will be applied to this limit. Once you have met your deductible, the plan pays 60% up to the 190% of Medicare Maximum Allowable Charge – not the billed amount. You are responsible for the difference between what the plan pays and the amount billed by your provider.

Maximunms for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Physical Exams</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adults only (age 18 and over)</td>
<td>100% per exam; no Calendar Year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Includes coverage for immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Adult Exams per 12 consecutive month period</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Well Child Exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Coverage for immunizations</td>
<td>100% per exam; no Calendar Year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum Well Child Exams:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First 12 months of life</td>
<td>7 exams</td>
<td></td>
</tr>
<tr>
<td>13th – 24th months of life</td>
<td>3 exams</td>
<td>Not Covered</td>
</tr>
<tr>
<td>25th – 36th months of life</td>
<td>3 exams</td>
<td></td>
</tr>
<tr>
<td>For age 3 to 18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Plan Features

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Exams per 12 months</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Screen &amp; Counseling Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obesity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Visits per 12 Months (this maximum applies only to Covered Persons ages 22 &amp; older.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misuse of Alcohol and/or Drugs – Maximum Visits per 12 months</td>
<td>26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Use of Tobacco Products Maximum Visits per 12 months</td>
<td>5 visits*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wellness Woman Care Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Gynecological Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical cancer, Chlamydia infections (for all sexually active women)</td>
<td>100% per exam; no Calendar Year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(As many as needed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Exams per Calendar Year</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine Cancer Screenings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Mammography</strong> for covered females age 40 and over*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% per test; no Calendar Year deductible applies</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Maximum tests per Calendar Year</td>
<td>1 test</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Maximum tests per Calendar Year</td>
<td>1 test</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* No age limit for those with a diagnosis of family history of Breast Cancer.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Baseline Mammogram age 35 – 39</td>
<td>1 test</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Prostate Specific Antigen Test for covered males age 40 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum tests per Calendar Year</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Routine Digital Rectal Exam for covered males age 40 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum tests per Calendar Year</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Routine Pap Test**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum tests per Calendar Year</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Fecal Occult Blood Test for covered individuals age 50 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum tests per Calendar Year</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Sigmoidoscopy for covered individuals age 50 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum Tests per 5 consecutive year period</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Double Contrast Barium Enema (DCBE) for covered individuals age 50 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum Tests per 5 consecutive year period</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

**Colonoscopy for covered individuals age 50 and over**

- 100% per test; no Calendar Year **deductible** applies
- Not Covered

<table>
<thead>
<tr>
<th>Maximum Tests per 5 consecutive year period</th>
<th>1 test</th>
<th>Not Covered</th>
</tr>
</thead>
</table>

* No age limit for those with a diagnosis of family history.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tubal Ligation</strong></td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td></td>
<td>100 %</td>
<td>No deductible</td>
</tr>
<tr>
<td><strong>Vision Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eye Examinations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>including refraction</td>
<td>90% after Calendar Year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per 24 consecutive month period</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Child under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit per 12 consecutive Month period</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Vision Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Vision Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>Maximum Benefit for All Vision Supplies per 12 consecutive month period.</td>
<td>$100</td>
</tr>
<tr>
<td>(Does not apply toward the plan’s deductible or annual coinsurance limit.)</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>$100 allowance for all hardware and contact lenses once every 12 months.</td>
<td>$75 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Child under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One pair of eyeglasses (lenses and frames)</td>
<td>OR one pair of contact lenses (or a 12 month supply) every 12 months or more frequently if medically necessary. In-Network Only</td>
<td></td>
</tr>
<tr>
<td>Additional discounts off retail hardware (e.g., 40% eyeglass frames) at participating providers. Call Aetna for details using the number on the back of your medical ID card.</td>
<td>Call Aetna for details using the number on the back of your medical ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Office Visits to Primary care physician</strong></td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Office Visits (non-surgical) to non-specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Office Visits</strong></td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Year deductible</td>
<td>Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Physician Office Visits -- Surgery</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Important Note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-network benefits may be reduced for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>multiple surgical procedures performed on the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>same day; see Limitations under Surgery under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What the Plan Covers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in clinics</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Non-Emergency Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Services for Inpatient Facility and</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of Anesthesia</td>
<td>90% per procedure after Calendar Year</td>
<td>60% per procedure after Calendar Year</td>
</tr>
<tr>
<td>deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>90% per visit after Calendar Year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum exams per 24 month period</td>
<td>1 exam</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Immunizations (when not part of the routine</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>physical exam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal Visits</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>After initial prenatal visits, subsequent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prenatal visits bundled with delivery and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>post-partum visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Facility</td>
<td>90% after Calendar Year deductible</td>
<td>90% after Calendar Year deductible</td>
</tr>
<tr>
<td>Important Notes:</td>
<td></td>
<td>See Important Notes Below</td>
</tr>
<tr>
<td>• Please note that as these providers are not</td>
<td></td>
<td></td>
</tr>
<tr>
<td>network providers and do not have a contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with Aetna, the provider may not accept payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of your cost share (your deductible and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>payment percentage) as payment in full. You</td>
<td></td>
<td></td>
</tr>
<tr>
<td>may receive a bill for the difference between</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the amount billed by the provider and the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>amount paid by this Plan. If the provider bills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you for an amount above your cost share, you are</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not responsible for paying that amount. Please</td>
<td></td>
<td></td>
</tr>
<tr>
<td>send us the bill at the address listed on the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>back of your member ID card and we will resolve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>any payment dispute with the provider over that</td>
<td></td>
<td></td>
</tr>
<tr>
<td>amount. Make sure your member ID number is on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the bill.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Your cost share will accumulate towards the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network deductible and coinsurance limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Non-Emergency care in a Hospital Emergency Room</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Medical Care</strong> (at a non-hospital free standing facility)</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Urgent Medical Care</strong> (from other than a non-hospital free standing facility)</td>
<td>Refer to Emergency Medical Services and Physician Services above</td>
<td>Refer to Emergency Medical Services and Physician Services above</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic and Preoperative Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic and Preoperative Testing</strong> (except complex imaging services)</td>
<td>90% per procedure after Calendar Year deductible</td>
<td>60% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Complex Imaging Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complex Imaging</strong></td>
<td>90% per procedure after Calendar Year deductible</td>
<td>60% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory Testing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory Testing</strong></td>
<td>90% per procedure after Calendar Year deductible</td>
<td>60% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays (except Complex Imaging Services)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic X-Rays</strong></td>
<td>90% per procedure after Calendar Year deductible</td>
<td>60% per procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performed in a Physician's Office Outpatient Surgery</strong></td>
<td>90% after Calendar Year deductible</td>
<td>60% per visit/surgical procedure after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Inpatient Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Birth center</strong></td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Hospital Facility Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Room and Board</strong> (including maternity)</td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Other than Room and Board</strong></td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Inpatient Facility</strong></td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>Maximum Benefit Per Calendar Year (Combined In and Out-of-Network)</td>
<td>120 days</td>
<td>120 days</td>
</tr>
</tbody>
</table>

**Specialty Benefits**

<table>
<thead>
<tr>
<th>Home Health Care Outpatient</th>
<th>90% per visit after Calendar Year deductible</th>
<th>60% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Per Calendar Year (Combined In and Out-of-Network)</td>
<td>120 days</td>
<td>120 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Duty Nursing (Outpatient)</th>
<th>90% per visit after Calendar Year deductible</th>
<th>60% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit Per Calendar Year (Combined In and Out-of-Network)</td>
<td>70 Private Duty Nursing Shifts. Eight (8) hours equals one shift.</td>
<td>70 Private Duty Nursing Shifts. Eight (8) hours equals one shift.</td>
</tr>
</tbody>
</table>

**Hospice Benefits**

<table>
<thead>
<tr>
<th>Hospice Care – Facility Expenses (Room and Board)</th>
<th>90% per admission after Calendar Year deductible</th>
<th>60% per admission after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care – Other Expenses during a stay</td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td>Maximum Benefit per Lifetime, Combination of In and Out-of-Network Combined</td>
<td>6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospice Outpatient Visits</th>
<th>90% per visit after Calendar Year deductible</th>
<th>60% per visit after Calendar Year deductible</th>
</tr>
</thead>
</table>

**Infertility Treatment**

<table>
<thead>
<tr>
<th>Basic Infertility Expenses</th>
<th>Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.</th>
<th>90% per visit after Calendar Year deductible</th>
<th>60% per visit after Calendar Year deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Infertility Expenses (Artificial Insemination, Ovulation Induction) and Advanced Reproductive Technology (ART) Expenses</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum for all Advanced Reproductive Technology (ART)</td>
<td>$30,000*</td>
<td>$30,000*</td>
<td></td>
</tr>
</tbody>
</table>

* Does not apply toward the plan out-of-pocket limit.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenses (including IVF, GIFT, ZIFT)</strong> (Combined In and Out-of-Network)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Mental Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Treatment of Mental Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Inpatient Treatment of Alcoholism and Substance Use Disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Treatment</td>
<td>90% per admission after Calendar Year deductible</td>
<td>60% per admission after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Outpatient Treatment of Alcoholism and Substance Use Disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Treatment and Group Therapy</td>
<td>90% per visit after Calendar Year deductible</td>
<td>70% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td><strong>Obesity Treatment Surgical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</td>
<td>90% per admission after Calendar Year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Related Outpatient Morbid Obesity Surgery</td>
<td>90% per service after Calendar Year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)</td>
<td>Unlimited</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

## Plan Features

<table>
<thead>
<tr>
<th>Network (IOE Facility)</th>
<th>Network (Non-IOE Facility)</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Reassignment Surgery</strong> (preauthorization required)</td>
<td>90% after the Calendar Year deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>$75,000</strong></td>
<td><strong>Lifetime Maximum</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Transplant Services Facility and Non-Facility Expenses**

<table>
<thead>
<tr>
<th>Transplant Facility and Physician Expenses</th>
<th>90% per admission after Calendar Year deductible</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Covered</strong></td>
<td><strong>Not Covered</strong></td>
<td></td>
</tr>
</tbody>
</table>

Your coverage will be considered network if provided at a participating Institute of excellence (IOE) facility only. Your coverage will be considered out-of-network if it is not provided at an Institute of excellence facility.

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Covered Health Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture in lieu of anesthesia</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Ground Ambulance (air or water ambulance only under certain conditions)</td>
<td>90% after Calendar Year deductible</td>
<td>90% after Calendar Year deductible</td>
</tr>
<tr>
<td>Durable Medical and Surgical Equipment</td>
<td>90% per item after Calendar Year deductible</td>
<td>60% per item after Calendar Year deductible</td>
</tr>
<tr>
<td>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>90% after Calendar Year deductible</td>
<td>60% after Calendar Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Therapies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Short Term Outpatient Rehabilitation Therapies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Physical, Occupational and Speech Therapy combined</strong></td>
<td>90% per visit after Calendar Year deductible</td>
<td>60% per visit after Calendar Year deductible</td>
</tr>
<tr>
<td>Combined In and Out-of-Network Physical, Occupational and Speech</td>
<td>120 visits</td>
<td>120 visits</td>
</tr>
</tbody>
</table>
# Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this Schedule of Benefits.

## Important Note about Prescription Medications administered through Express Scripts

Coverage for prescription medications through Express Scripts is integrated into the Aetna HDHP. Medications on Express Script’s preventive list are not subject to the deductible. Coverage for prescription medications as it relates to the deductible and coinsurance limits is as follows.

Until the network deductible is met:

- For prescription medications on Express Scripts’ preventive list, the member pays a copay and the plan pays 100% of the remaining cost. The copay does not count toward the network deductible.

- For prescription medications not on Express Scripts’ preventive list, the plan pays no benefit until the deductible is met. The member pays the discounted price negotiated by Express Scripts’, which is counted towards the network deductible.

Once the network deductible limit is met:

- The member pays a copay for all medications (preventive and non-preventive). All prescription medication copays count toward the network coinsurance limit.

After the network coinsurance limit is met:

- Prescription medications on Express Scripts’ preventive list are covered by the plan at 100%.
- Copays continue to apply to prescription medications not on Express Scripts’ preventive list.
Deductible Provisions

In-network and out-of-network covered expenses are accumulated separately towards separate deductibles. Network covered expenses and Express Scripts prescription medications not on the preventive list will be applied to satisfy the Network Calendar Year Deductible, and out-of-network covered expenses will be applied to satisfy the Out-of-Network Calendar Year Deductible. The plan pays a percentage of the applicable covered expenses once the respective deductible limit is met. For example, if an individual has met the network deductible limit but not the out-of-network deductible limit, the plan will pay a percentage of network covered expenses but nothing on the out-of-network covered expenses that are still accumulating toward the out-of-network deductible limit.

Network Calendar Year Deductible
This is the maximum amount of network covered expenses to be incurred each Calendar Year before any benefit will be paid from the plan. Wellness benefits (including routine physical exams, Well Child Exams, and Routine Cancer Screenings) and prescription medications on the preventive list are not subject to the deductible.

The plan accumulates covered expense towards the network deductible on both an individual and, in the case of family coverage, on a combined family basis. Wellness benefits (described above) are not counted toward the network deductible, nor are copays paid for Express Scripts prescription medication on the preventive list. The discounted, negotiated price for all other covered expenses is counted towards the network deductible.

Network Individual and Family Deductible Limit
The plan has an Individual and Family Deductible Limit. For purposes of this provision, an individual means a person enrolled for self-only coverage with no dependent coverage and a family means a person enrolled with one or more dependents.

Once the amount of covered expenses incurred by an individual during the Calendar Year meets the individual deductible limit, the plan will pay a percentage of covered expenses for that person for the remainder of the Calendar Year except for Express Scripts prescription medications not on the preventive list, which the plan covers at 100% except for a copay until the annual network coinsurance limit is met.

The family deductible limit can be met with a combination of family members or by any single individual within the family. When this limit is reached, the plan will pay a percentage of the family's covered expenses for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible
This is the maximum amount of out-of-network covered expense to be incurred each Calendar Year before any benefit will be paid from the plan.

Out-of-Network Individual Deductible Limit
The plan will pay a percentage of covered expenses incurred by a single individual who has reached the individual deductible limit.
Payment Provisions

Payment percentage
This is the percentage of covered expenses that the plan pays and the percentage of covered expense that you pay. (This cost-sharing is referred to as “coinsurance”.) The percentage that the plan pays is referred to as the “Plan Payment percentage”. Once applicable deductible has been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs except as noted otherwise above for Express Scripts prescription medications. The payment percentage may vary by type of expense. Refer to your Schedule of Benefits for the payment percentage amounts for each covered benefit. For out-of-network benefits, the payment percentage will be applied to the lesser of the actual charge or 190% of the Medicare Maximum Allowable charge.

Network and Out-of-Network Coinsurance Limits
The coinsurance limit is the maximum amount you are responsible to pay for covered expense during the Calendar Year. (This also called the “out-of-pocket maximum.”) In-network expenses, including the copays for Express Scripts prescription medications are accumulated toward the network coinsurance limit. Out-of-network covered expenses are accumulated separately towards the out-of-network coinsurance limit.

Once you satisfy the network coinsurance limit, the plan will pay 100% of the network covered expenses. Similarly, once the out-of-network coinsurance limit is met, the plan will pay 100% of the out-of-network covered expenses that apply toward the limit for the rest of the calendar year.

Each coinsurance limit, network and out-of-network, has both an Individual and Family Coinsurance Limit. For purposes of this provision, an individual means a person enrolled for self-only coverage with no dependent coverage and a family means a person enrolled with one or more dependents.

Once the amount of covered expenses incurred by an individual during the Calendar Year meets the Individual Coinsurance Limit, the plan will pay 100% of covered expenses for that person for the remainder of the Calendar Year except...

The Family Coinsurance Limit can be met with a combination of family members or by any single individual within the family. Once the Family Coinsurance Limit is reached, the plan will pay 100% of the family's covered expenses for the rest of the Calendar Year.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan out-of-pocket limits. These include:

- Charges over the recognized charge (which includes any amount exceeding 190% of the Medicare Maximum Allowable Charge for out-of-network covered expenses);
- Comprehensive Infertility Expenses and ART
- Non-covered expenses
- Any covered expenses which are payable by Aetna at 50%
- Expenses that are not paid, or precertification benefit reductions because a required precertification for service(s) or supply was not obtained from Aetna.
**General**

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your *Booklet* and should be kept with your *Booklet*.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

**Health Savings Account (HSA)**

- If you elect the HDHP and are not enrolled in Medicare, you can elect the HSA.
- It can be used for current or future qualified healthcare expenses, including when you are retired.
- Any money you have not used at the end of the calendar year rolls over to the next year.

**Features of Your HSA**

- JPMorgan Chase is the administrator of the HSA.
- Each year, you can contribute up to the federally determined maximum for Yourself and Spouse/Same-Sex Domestic Partner/Child or Family coverage. Any unused balance accumulates year over year and the cumulative balance can exceed the annual contribution maximum. If you are at least age 55 and are not enrolled in Medicare, you can make “catch-up” contributions to your HSA.
- Important for same-sex domestic partners: Internal Revenue Service rules do not allow you to use your HSA to reimburse yourself for the expenses of your same-sex domestic partner or his/her children unless you are legally married and live in DC or one of the states that recognize same-sex marriage.
- You can contribute money to your account on a pre-tax basis through payroll deductions and change your elections at any time.
- You must be enrolled in the HDHP to be eligible to contribute to an HSA. (For example, if you are enrolled in one of the POS Plans or an HMO, you are not eligible to contribute to the HSA.)
- Once you are enrolled in Medicare, you are no longer eligible to make pre-tax contributions to your HSA through the University.
- Under Internal Revenue Service (IRS) regulations, if you enroll in the HSA, you cannot participate in any healthcare flexible spending account (FSA) because you can use your HSA to pay for eligible healthcare expenses.
- Qualified medical expenses that may be paid through your HSA on tax-free basis include most medical care and services; dental and vision care; prescription drugs; and premiums paid for COBRA, long-term care and post-retirement Medicare coverage. You can see a complete list of eligible expenses at [www.irs.gov](http://www.irs.gov) (Publications 969 and 502).
- You will not be eligible to establish or contribute to an HSA if you are covered by another medical plan that is not an HSA-qualified HDHP (e.g., a spouse’s employer’s non-HDHP coverage.) In addition, if your spouse participates in a healthcare FSA that permits reimbursement of your unreimbursed medical expenses, then you will not be eligible to establish or contribute to an HSA until you are no longer covered by your spouse’s healthcare FSA.
- If you withdraw money from your HSA to pay for non-qualified expenses, you’ll pay taxes on that distribution and an additional 20% penalty if you’re under age 65.
- You should keep careful records of your healthcare expenses and the corresponding withdrawal from your HSA, in case you need to provide proof to the IRS of your account distributions.
If you have an account balance of at least $2,000, you can choose to invest among nine investment options. Any earnings you invest through your HSA are automatically reinvested and grow tax-free.

- There is no tax on investment earnings in the HSA.
- You do not pay taxes on the money you withdraw to pay for current and/or future qualified healthcare expenses, including deductible and coinsurance.
- The HSA is portable – it is yours to keep if you change health plans, leave Columbia or retire.
- You can use an HSA debit card to pay providers directly from your account. You can also pay bills online or have money automatically withdrawn from your HSA to pay for qualified medical expenses.

Use Aetna Navigator™ to Manage Your HDHP and HSA

After you enroll in the HDHP, be sure to register on Aetna Navigator, which provides tools and resources to help you manage your HDHP. On the site, you can:

- View your HSA balance, check eligibility, review the status of your claims and download claims history.
- Compare estimated costs for healthcare services in your area.
- Compare area hospitals based on what is most important to you.
- Calculate how much you can put into your HSA, in a month or year.
- See how your HSA balance can grow over time and compare those savings to other options.
- Get trusted health and wellness information.
- Find participating doctors using Aetna’s DocFind® online directory.

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

Other Plans Not Including Medicare

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

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

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

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent, except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
a. secondary to the plan covering the person as a dependent; and  
b. 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:  
c. covers the person as other than a dependent; and  
d. is secondary to Medicare.  

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time. If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.  

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

a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.  
b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.  
c. If there is not such a court decree:  
d. 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.  
e. 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.

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

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

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar 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.
General Provisions

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

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

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

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

Additional Provisions
The following additional provisions apply to your coverage:

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

Assignments
Coverage may be assigned only with the written consent of Aetna. To the extent allowed by law, Aetna will not accept an assignment to an out-of-network provider, provider or facility including but not limited to, an assignment of:
- The benefits due under this contract;
- The right to receive payments due under this contract; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this contract.

**Misstatements**

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

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

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

**Incontestability**

As to Accident and Health Benefits:

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

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

**Subrogation and Right of Recovery Provision**

**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, from such payment, 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 or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes 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 the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, 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.

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 or 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 or 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 or her by reason of his or her present or future domicile.

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

The Recovery Rights will be applied even though:

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

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

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

### Recovery of Overpayments

**Health Coverage**

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

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

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

**Reporting of Claims**

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

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

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

**Payment of Benefits**

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

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

Aetna will notify you in writing, at the time it receives a claim, when an assignment of benefits to a health care provider or facility will not be accepted.
The Plan may pay up to $1,000 of any other 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.

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

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

Very important are:

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

**Appeals Procedure**

**Definitions**

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

Such adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is experimental or investigational; or
- A determination that the service or supply is not medically necessary.

**Appeal:** A written request to Aetna to reconsider an adverse benefit determination.

**Complaint:** Any written expression of dissatisfaction about quality of care or the operation of the Plan.

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

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

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

**Post-Service Claim:** Any claim that is not a “Pre-Service Claim.”

**Urgent Care Claim:** Any claim for medical care or treatment in which a delay in treatment could:

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

Claim Determinations

Urgent Care Claims
Aetna will make notification of an urgent care claim determination as soon as possible but not more
than 72 hours after the claim is made.

If more information is needed to make an urgent claim determination, Aetna will notify the claimant within
24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna
with the additional information. Aetna will notify the claimant within 48 hours of the earlier of the receipt of
the additional information or the end of the 48 hour period given the physician to provide Aetna with the
information.

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

Pre-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 15 calendar
days after the pre-service claim is made. Aetna may determine that due to matters beyond its control an
extension of this 15 calendar days claim determination period is required. Such an extension, of not
longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15 calendar
days period. If this extension is needed because Aetna needs additional information to make a claim
determination, the notice of the extension shall specifically describe the required information. You will
have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Post-Service Claims
Aetna will make notification of a claim determination as soon as possible but not later than 30 calendar
days after the post-service claim is made. Aetna may determine that due to matters beyond its control an
extension of this 30 calendar day claim determination period is required. Such an extension, of not longer
than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30 calendar day
period. If this extension is needed because Aetna needs additional information to make a claim
determination, the notice of the extension shall specifically describe the required information. The patient
will have 45 calendar days, from the date of the notice, to provide Aetna with the required information.

Concurrent Care Claim Extension
Following a request for a concurrent care claim extension, Aetna will make notification of a claim
determination for emergency or urgent care as soon as possible but not later than 24 hours, with
respect to emergency or urgent care provided the request is received at least 24 hours prior to the
expiration of the approved course of treatment, and 15 calendar days with respect to all other care,
following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination
Aetna will make notification of a claim determination to reduce or terminate a previously approved course
of treatment with enough time for you to file an appeal.
Complaints
If you are dissatisfied with the service you receive from the Plan or want to complain about a provider you must write Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

Appeals of Adverse Benefit Determinations
You may submit an appeal if Aetna gives notice of an adverse benefit determination. This Plan provides for two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

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

The notice of an adverse benefit determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna’s Customer Service Unit at the toll-free phone number on your ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One Appeal - Group Health Claims
A level one appeal of an adverse benefit determination shall be provided by Aetna personnel not involved in making the adverse benefit determination.

Urgent Care Claims (May include concurrent care claim reduction or termination)
Aetna shall issue a decision within 36 hours of receipt of the request for an appeal.

Pre-Service Claims (May include concurrent care claim reduction or termination)
Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

Post-Service Claims
Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

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.

**Level Two Appeal**

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative have the right to file a level two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level one appeal.

A level two appeal of an adverse benefit determination of an urgent care claim, a Pre-Service Claim, or a Post-Service Claim shall be provided by Aetna personnel not involved in making an adverse benefit determination.

**Urgent Care Claims** (May include concurrent care claim reduction or termination)

Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal.

**Pre-Service Claims** (May include concurrent care claim reduction or termination)

Aetna shall issue a decision within 15 calendar days of receipt of the request for level two appeal.

**Post-Service Claims**

Aetna shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

**External Review Procedure**

The external review program offers members the opportunity to have certain coverage denials reviewed by independent physician reviewers. Once the applicable plan appeal process has been exhausted, eligible members may request external review if the coverage denial for which the member would be financially responsible involves more than $500 and is based on lack of medical necessity or on the experimental or investigational nature of the service or supply at issue.

If, upon the final level of review, Aetna upholds the coverage denial and it is determined that the member may be eligible for external review, he or she will be informed in writing of the steps necessary to request an external review, and a Request for External Review form will be included with the letter.

If coverage has been denied and the coverage denial letter indicates that the member is not eligible to request external review of the coverage denial, he or she should review the information below to determine if the coverage denial meets eligibility criteria to participate in this program.

The cost of the service or supply at issue for which the member would be financially responsible exceeds $500.

The applicable plan appeal process has been exhausted.

If the above eligibility criteria have been met and the applicable state external review process does not require otherwise, the member should print the Request for External Review form, follow the instructions
provided on the form, and submit all information to Aetna’s External Review Unit at the address listed on the form for processing.

A second form, Request for Expedited External Review form, is for use by the treating physician, if he or she certifies that a delay in service would jeopardize the member’s health.

The Aetna External Review Unit will refer the request to an independent review organization (IRO) contracted with Aetna, and the IRO will choose an appropriate independent physician reviewer (or reviewers, if necessary or required by applicable law) to examine the case. The IRO is responsible for choosing a physician who is board certified in the area of medical specialty at issue in the case. The physician reviewer must take an evidence-based approach to reviewing the coverage determination, and must follow the plan sponsor’s plan documents and applicable criteria governing the member’s benefits.

After all necessary information is submitted, external reviews generally will be decided within 30 calendar 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. Once the review is complete, the decision of the independent external reviewer will be binding on Aetna, the plan sponsor and the health plan. Members are not charged a professional fee for the review.

Exhaustion of Process
You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you:

- establish any:
  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Effect of Benefits Under Other Plans

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 will be excluded from medical expense 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 group policy anniversary date after 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 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 providing medical coverage. 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.

**Discount Programs**

**Discount Arrangements**

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

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

**Incentives**

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your physician or other service providers, we may, from time to time, offer to waive or reduce a member’s copayment, coinsurance, and/or a deductible otherwise required under the plan or offer coupons or other financial incentives. We have 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.
Glossary

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

A

Accident

This means a sudden; unexpected; and unforeseen; identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Contract. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.

Aetna

Aetna Life Insurance Company

Ambulance

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

Average Wholesale Price (AWP)

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

B

Behavioral health provider/practitioner

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

Birthing center

A freestanding facility that meets all of the following requirements:

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

Body Mass Index

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

C

Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the Schedule of Benefits.

Cosmetic

Services or supplies that alter, improve or enhance appearance.

Covered Expenses

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

Creditable Coverage

A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:
• Health coverage issued on a group or individual basis;
• Medicare;
• Medicaid;
• Health care for members of the uniformed services;
• A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees’ Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children’s Health Insurance Program (S-Chip).

**Custodial Care**

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

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

**D**

**Day Care Treatment**

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

**Deductible**

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

**Dentist**

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

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

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

as determined by a physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

**Directory**

A listing of all network providers serving the class of employees to which you belong. The contractholder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

**Durable Medical and Surgical Equipment (DME)**

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

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

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

**Effective treatment of a mental disorder**

This is a program that:

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

**Emergency care**

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

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

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

**Experimental or Investigational**

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

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

**G**

**Generic prescription drug**

A prescription drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by Aetna or an affiliate.

**H**

**Homebound**

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

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

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

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.
Home health care agency
An agency that meets all of the following requirements.

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

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

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

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

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

- Has hospice care available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - Skilled nursing services;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for terminally ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One physician;
  - One R.N.; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how hospice care is provided.
• Assesses the patient’s medical and social needs.
• Develops a hospice care program to meet those needs.
• Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
• Permits all area medical personnel to utilize its services for their patients.
• Keeps a medical record on each patient.
• Uses volunteers trained in providing services for non-medical needs.
• Has a full-time administrator.

Hospice care program
This is a written plan of hospice care, which:
• Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
• Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
• Includes an assessment of the person’s medical and social needs; and a description of the care to be given to meet those needs.

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

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

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

**Hospitalization**

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

**Illness**

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

**Infertile or Infertility**

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

• For a **woman** who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or

• For a **woman** who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

**Injury**

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

• An unexpected or reasonably unforeseen occurrence or event; or

• The reasonable unforeseeable consequences of a voluntary act by the person.

• An act or event must be definite as to time and place.

**Institute of excellence (IOE)**

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

**Jaw Joint Disorder**

This is:

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

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 Booklet.

Lifetime maximum
This is the most the plan will pay for covered expenses incurred by any one covered person during their lifetime.

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

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

Maintenance care
Care made up of services and supplies that:
• Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and
• Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

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

The following expenses do not apply toward your maximum out-of-pocket limit(s):
• Charges over the recognized charge,
• Any covered expenses which are payable by Aetna at 50%,
• Non-covered expenses, and
• Expenses that are not paid or precert benefit reductions made because a required precertification for the service(s) or supply was not obtained from Aetna.
Medically necessary or Medical necessity

Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

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

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

Mental Disorder

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

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

Morbid obesity

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

Negotiated charge

The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.
Network advanced reproductive technology (ART) specialist

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

Network provider

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

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

Network Service(s) or Supply(ies)

Health care service or supply that is:

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

Night Care Treatment

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

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

Non-occupational illness

A non-occupational illness is an illness that does not:

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

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

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

Non-occupational injury

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

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

Non-specialist

A physician who is not a specialist.

Non-urgent admission
An inpatient admission that is not an emergency admission or an urgent admission.

O

Occupational injury or Occupational illness

An injury or illness that:

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

Occurrence

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

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

Other health care

A health care service or supply that is neither network service(s) or supply(ies) nor out-of-network service(s) and supply(ies). Other health care can include care given by a provider who does not fall into any of the categories in your provider directory (or in DocFind at Aetna’s website).

Out-of-network service(s) and Supply(ies)

Health care service or supply that is:

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

Out-of-network provider

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

P

Partial confinement treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, substance use disorder, or mental disorders. The plan must meet these tests:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.
- Day care treatment and night care treatment are considered partial confinement treatment.
Payment percentage

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

Payment limit

Payment limit is the maximum out-of-pocket amount you are responsible to pay for your payment percentage for covered expenses during your calendar year. Once you satisfy the payment limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the calendar year. You have separate payment limits for network and out-of-network benefits. The following expenses do not apply toward your payment limit:

- Charges over the recognized charge;
- Any covered expenses which are payable by Aetna at 50%;
- Non-covered expenses;
- Certain other covered expenses; and
- Expenses that are not paid or precert benefit reductions that are made because a required precertification for the service(s) or supply was not obtained from Aetna.

Pharmacy

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

Physician

A duly licensed member of a medical profession who:

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

This also includes a health professional who:

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

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

Prescriber

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

Prescription

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

Prescription drug

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

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

Primary care physician (PCP)

This is the network provider who:

- Is selected by a person from the list of primary care physicians in the directory.
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
- Initiates referrals for specialist care and maintains continuity of patient care; and
- Is shown on Aetna's records as the person's PCP.

Psychiatric hospital

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

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

**Psychiatric physician**

This is a physician who:

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

**R**

**Recognized charge**

The **covered expense** is only that part of a charge which is the **recognized charge**.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - 190% of the Medicare Allowable Rate for the Geographic Area where the service is furnished.

If **Aetna** has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that **Aetna** will pay for a service or supply, then the recognized charge is the rate established in such agreement.

**Aetna** may also reduce the recognized charge by applying **Aetna Reimbursement Policies**. **Aetna** Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

**Aetna** Reimbursement Policies are based on **Aetna’s** review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations;
and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Medicare Allowable Rates are defined as follows:

- Geographic Area: This means an expense area grouping 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, the grouping never crosses state lines.

- Medicare Allowable Rates: These are the rates established and periodically updated by The Centers for Medicare and Medicaid Services (CMS) for payment for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate for a particular service, the rate will be based on the same method that CMS uses to set Medicare rates.

**Important Note:**

Aetna periodically updates its systems with changes made to the Medicare Allowable Rates.

What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

**Additional Information**

Aetna’s website Aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools, or contact our Customer Service Department for assistance.

**Rehabilitation facility**

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

**Rehabilitative Services**

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

**Residential treatment facility (Alcoholism and Substance use disorder)**

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

- On-site licensed Behavioral health provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
• If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.

• Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.

• Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

• Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).

• Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.

• Has peer oriented activities.

• Services are managed by a licensed **Behavioral health provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

• Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.

• Provides a level of skilled intervention consistent with patient risk.

• Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

• Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

• Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.

• 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.

• On-site, licensed **Behavioral health provider**, medical or **substance use disorder** professionals 24 hours per day/7 days a week.

**Residential treatment facility (Mental Disorders)**

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

• On-site licensed **Behavioral health provider** 24 hours per day/7 days a week.

• Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).

• Is admitted by a **Physician**.

• Has access to necessary medical services 24 hours per day/7 days a week.

• Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.

• Offers group therapy sessions with at least an RN or Masters-Level Health Professional.

• Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).

• Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.

• Has peer oriented activities.
• Services are managed by a licensed Behavioral health provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

• Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.

• Provides a level of skilled intervention consistent with patient risk.

• Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

• Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.
A registered nurse.

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

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

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

Skilled nursing facility
An institution that meets all of the following requirements:

• It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  ♦ Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  ♦ Physical restoration services to help patients to meet a goal of self-care in daily living activities.

• Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.

• Is supervised full-time by a physician or an R.N.

• Keeps a complete medical record on each patient.

• Has a utilization review plan.

• Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.

• Charges patients for its services.

• An institution or a distinct part of an institution that meets all of the following requirements:
It is licensed or approved under state or local law.
• Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

• Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  ◆ The Joint Commission on Accreditation of Health Care Organizations;
  ◆ The Bureau of Hospitals of the American Osteopathic Association; or
  ◆ The Commission on the Accreditation of Rehabilitative Facilities

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

Skilled nursing facility does not include:

• Institutions which provide only:
  ◆ Minimal care;
  ◆ Custodial care services;
  ◆ Ambulatory; or
  ◆ Part-time care services.

• Institutions which primarily provide for the care and treatment of alcoholism, substance use or mental disorders.

Skilled nursing services

Services that meet all of the following requirements:

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

Specialist

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

Specialty care

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

Stay

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

Substance use disorder

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

**Surgery center**

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.

- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:

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

Terminally ill (Hospice Care)

Terminally ill means a medical prognosis of 6 months or less to live.
U

Urgent Admission

A hospital admission by a physician due to:

- The onset of or change in an illness; or
- The diagnosis of an illness; or
- An injury.

- The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent care provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person’s physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - 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 network urgent care provider.

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

Urgent condition

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

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

W

Walk-in clinic
Walk-in clinics are free-standing health care facilities. They are an alternative to a physician’s office visit for treatment of unscheduled, non-emergency illnesses and injuries 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.