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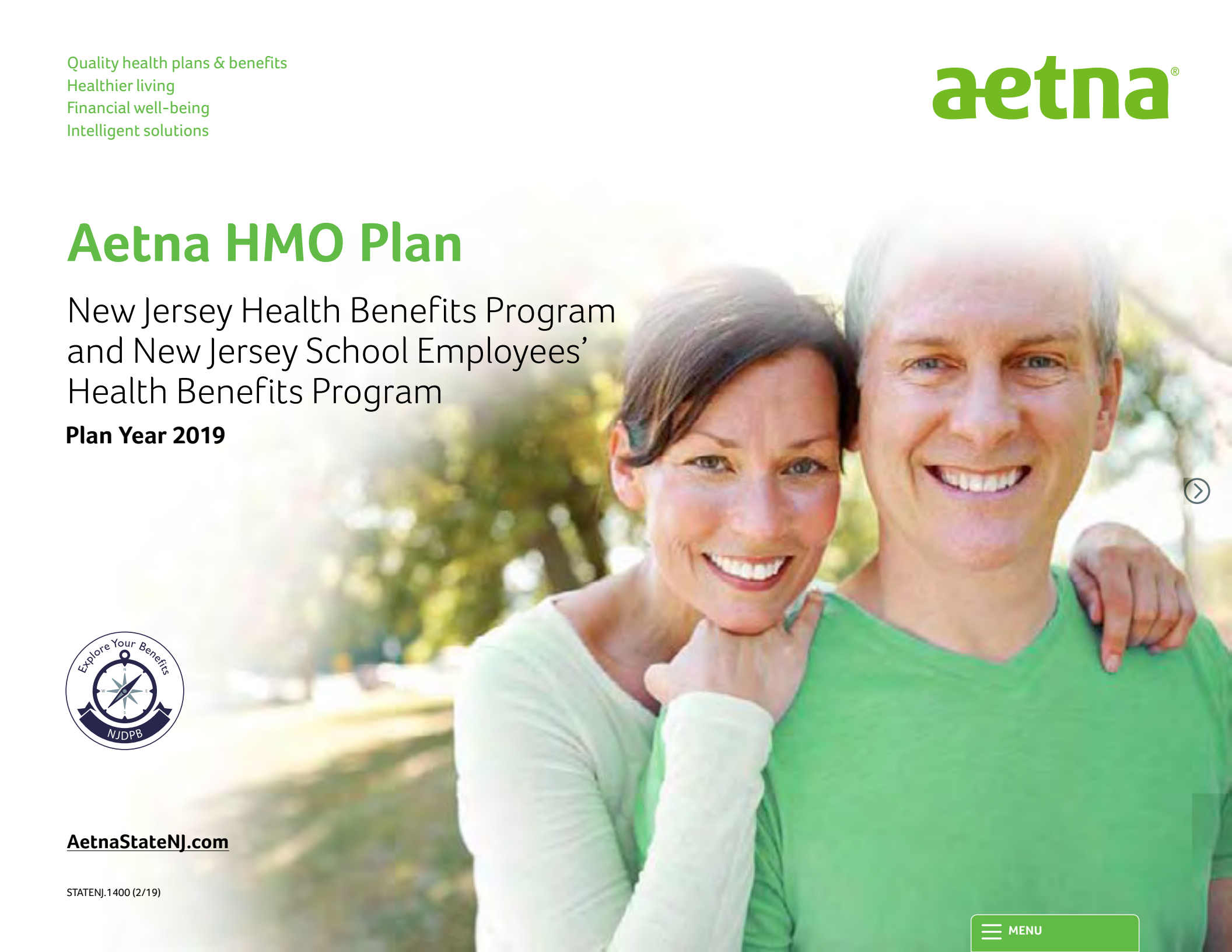
Aetna HMO Plan

New Jersey Health Benefits Program and New Jersey School Employees' Health Benefits Program

Plan Year 2019



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WELCOME

Our goal is your good health. To achieve this goal, we encourage preventive care in addition to covering you when you are sick or injured. An extensive network of participating physicians and hospitals is available to provide you with easy access to medical care 24 hours a day, 7 days a week.

We believe that through the appropriate use of health resources, we can work together to keep you healthy and to control the rising costs of medical care for everyone.

Your Aetna HMO Plan options are self-funded by the State of New Jersey and administered by Aetna Life Insurance Company (Aetna).

An online version of this guidebook containing current updates is available for viewing over the Division of Pensions and Benefits website at state.nj.us/treasury/pensions/health-benefits.shtml.

Be sure to check the website for related forms, fact sheets, and news of any developments affecting the benefits provided under the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP).

You can also check the custom Aetna website at AetnaStateNJ.com for medical and dental plan documents, discount program information and numerous other helpful resources.

Every effort has been made to ensure the accuracy of the Aetna Member Guidebook, which describes the benefits provided and is an amendment to the contract with Aetna. However, State law and the New Jersey Administrative Code govern the SHBP and SEHBP. If there are discrepancies between the information presented in this guidebook and the law, regulations or contract, or the Divisions of Pensions documents, the latter will govern.

We wish you the best of health.

Your Member Guidebook

This member guidebook is your guide to the benefits available through the Aetna HMO Plan (referred to in this guidebook as the Plan). Please read the guidebook carefully and refer to it when you need information about how the Plan works, what the Plan covers and how this Plan coordinates with other coverages you may have. It is also an excellent source for learning about many of the special programs available to you as an Aetna plan participant.

If you cannot find the answer to your question(s) in the member guidebook, call the Member Services toll-free number shown on your ID card. A trained representative will be happy to help you.

Tips for New Plan Participants

- Keep this booklet where you can easily refer to it.
- Keep your ID card(s) in your wallet.
- Post your Primary Care Physician's name and number near the telephone.

How to use this booklet

Live Link

Opens new browser window

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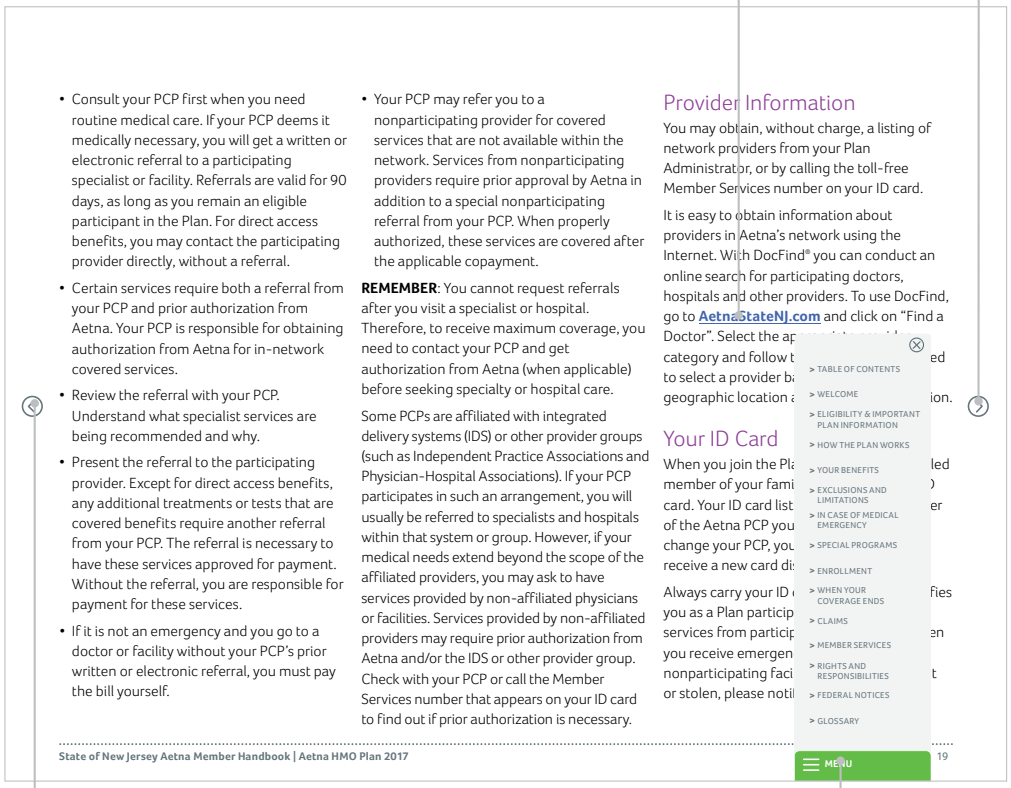

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Eligibility & Important Plan Information

Active Employee Eligibility

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) and SEHBP. Enrollments, terminations, changes to coverage, address changes, etc. must be presented through your employer to either the SHBP and SEHBP. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits, Office of Client Services at **(609) 292-7524** or pensions.nj@treas.state.nj.us.

State Employees

To be eligible for State employee coverage, you must work full-time for the State of New Jersey or be an appointed or an elected officer of the State of New Jersey (this includes employees of a State agency or authority and employees of a State college or university). For State employees, full-time requires 35 hours per week or more if required by contract or resolution.

State Part-Time Employees

A part-time employee of the State — or a part-time faculty member at an institution of higher education that participates in the SHBP — will be eligible for coverage under a SHBP medical plan and the Prescription Drug Plans if the employee is also enrolled in a State-administered retirement system. The employee must pay the full cost of the coverage. A part-time employee will not qualify for employer or State-paid post retirement health care benefits, but may enroll in the SHBP Retired Group at their own expense provided the employee was covered by the SHBP up to the date of retirement. See Fact Sheet #66, Health Benefits Coverage for Part-Time Employees, for details.

Local Employees

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary from a local employer (county, municipality, county or municipal authority, board of education, etc.) that participates in the SHBP and SEHBP. Each participating local employer defines the minimum hours required for full-time by a resolution filed with the Division of Pensions and Benefits, but it can be no less than 25 hours per week or more if required by contract or resolution. Employment must also be for 12 months per year, except for employees whose usual work schedule is 10 months per year (the standard school year).

Enrollment

You are not covered until you enroll in the SHBP and SEHBP. You must fill out a Health Benefits Program Application and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so. Open Enrollment periods occur once a year usually during the month of October. Information about the dates of the Open Enrollment period and effective dates for coverage is announced by the Division of Pensions and Benefits.

Eligible Dependents

Your eligible dependents are your spouse, civil union partner, or eligible same-sex domestic partner and/or your eligible children (see definitions below). An eligible individual may only enroll in the SHBP and SEHBP as an employee or retiree, or be covered as a dependent. Eligible children may only be covered by one participating subscriber.

Spouse – is a person to whom you are legally married. A photocopy of the Marriage Certificate and additional supporting documentation are required for enrollment.

Civil Union Partner – is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey Civil Union Certificate or a valid certification from another jurisdiction that recognizes same sex civil unions and additional supporting documentation are required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or Fact Sheet #75, Civil Unions, for details).

Domestic Partner – is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey Certificate of Domestic Partnership dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners and additional supporting documentation are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, Benefits Under the Domestic Partnership Act, for details).

Children – In compliance with the federal Patient Protection and Affordable Care Act (ACA), coverage is extended for children until age 26. This includes natural children under age 26 regardless of the child's marital, student, or financial dependency status. A photocopy of the child's birth certificate that includes the covered parent's name is required for enrollment. For a stepchild provide a photocopy of the child's birth certificate showing the spouse/partner's name as a parent and a photocopy of marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.

Foster children and children in a guardian-ward relationship under age 26 are also eligible. A photocopy of the child's birth certificate and additional supporting legal documentation are required with enrollment forms for these cases. Documents must attest to the legal guardianship by the covered employee.

Dependents of dependents are not covered under the SHBP and SEHBP plan.

Coverage for an enrolled child ends on December 31 of the year in which he or she turns age 26 (see the "COBRA" section, "Dependent Children with Disabilities" and "Over Age Children until Age 31" below for continuation of coverage provisions).

Dependent Children with Disabilities – If a child is not capable of self-support when he or she reaches age 26 due to mental illness, mental retardation, or a physical disability, he or she may be eligible for a continuance of coverage.

To request continued coverage, contact the Office of Client Services at **(609) 292-7524** or write to the **Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625** for a Continuance for Dependent with Disabilities form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 26, you have until January 31 to file the Continuance for Dependent with Disabilities form. Coverage

for children with disabilities may continue only while (1) you are covered through the SHBP and SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance and lives with you. You will be contacted periodically to verify that the child remains eligible for continued coverage. See Fact Sheet #51, Continuing Health Benefits Coverage for Over Age Children with Disabilities, for more information. Additional information is repeated later in this guidebook.

Over Age Children until Age 31 – Certain children over age 26 may be eligible for coverage until age 31 under the provisions of Chapter 375, P.L. 2005, as amended by Chapter 38, P.L. 2008. This includes a child by blood or law who is under the age of 31; is unmarried; has no dependent(s) of his or her own; is a resident of New Jersey or is a full-time student at an accredited public or private institution of higher education; and is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.

Under Chapter 375, an over age child does not have any choice in the selection of benefits but is enrolled for coverage in exactly the same plan or plans (medical and/or prescription drug) that the covered parent has selected. The covered parent or child is responsible for the entire cost of coverage. There is no provision for dental or vision benefits.

Coverage for an enrolled over age child will end when the child no longer meets any one of the eligibility requirements or if the required payment is not received. Coverage will also end when the covered parent's coverage ends. Coverage ends on the first of the month following the event that makes the dependent ineligible or up until the paid through date in the case of non-payment. See Fact Sheet #74, Health Benefits Coverage of Children until Age 31 under Chapter 375, for details.

Supporting Documentation Required for the Enrollment of Dependents

The SHBP and SEHBP are required to ensure that only eligible employees and retirees, and their dependents, are receiving health care coverage under the program. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled dependents, and over age children continuing coverage) must submit supporting documentation in addition to the enrollment application.

Audit of Dependent Coverage

The Division of Pensions and Benefits periodically performs audits using a random sample of members to determine if enrolled dependents are eligible under plan provisions. Proof of dependency such as a marriage, civil union, or birth certificates, or tax returns are required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination of ALL coverage and may include financial restitution for claims paid. Members who are found to have intentionally enrolled an ineligible person for coverage will be prosecuted to the fullest extent of the law.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent. Eligible children may only be covered by one participating subscriber. For example, a husband and wife both have coverage based on their employment and have children

eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Medicare Coverage While Employed

In general, it is not necessary for a Medicare-eligible employee, spouse, civil union partner, eligible same-sex domestic partner, or dependent child(ren) to be covered by Medicare while the employee remains actively at work. However, if you or your dependents become eligible for Medicare due to End Stage Renal Disease (ESRD) you and/or your dependents must enroll in Medicare Parts A and B even though you are actively at work.

Medicare Eligibility by Reasons of End Stage Renal Disease

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse, civil union partner, or domestic partner).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules described above, known as the Medicare Secondary Payer (MSP) rules, are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time. As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts:

- An initial three-month waiting period;
- A "coordination of benefits" period; and
- A period where Medicare is primary.

Three-month Waiting Period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three- month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of Benefits Period

During the "coordination of benefits" period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is Primary

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary. For any retiree who is enrolled in the Aetna Medicare Plan (HMO) (after becoming entitled to Medicare Part A and Part B), the Aetna Medicare Plan (HMO) will be the primary insurance plan.

Retiree Eligibility

Eligibility for coverage is determined by the State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP). Enrollments, terminations, changes to coverage, address changes, etc. must be presented to the SHBP/SEHBP directly. If you have any questions concerning eligibility provisions, you should contact the Division of Pensions and Benefits, Office of Client Services at **(609) 292-7524** or **pensions.nj@treas.state.nj.us**.

- Full-time State employees, employees of State colleges/universities, autonomous State agencies and commissions, or local employees who were covered by, or eligible for, the SHBP at the time of retirement and begin receiving a monthly retirement benefit or lifetime annuity immediately following termination of employment.
- Part-time State employees and part-time faculty at institutions of higher education that participate in the SHBP if enrolled in the SHBP at the time of retirement.
- Participants in the Alternate Benefit Program (ABP) eligible for the SHBP who retire with at least 25 years of credited ABP service or those who are on a long term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.
- Certain local policemen or firemen with 25 years or more of service credit in the retirement system or retiring on a disability retirement if the employer does not provide any payment or compensation toward the cost of the retiree's health benefits. A qualified retiree may enroll at the time of retirement or when he or she becomes eligible for Medicare. See Fact Sheet #47, *Retired Health Benefits Coverage under Chapter 330*, for more information.
- Surviving spouses, civil union partners, eligible same-sex domestic partners, and children of Police and Firemen's Retirement System (PFRS) members or State Police Retirement System (SPRS) members killed in the line of duty.

The following individuals will be offered SEHBP Retired Group coverage for themselves and their eligible dependents:

- Full-time members of the Teachers' Pension and Annuity Fund (TPAF) and school board or county college employees enrolled in the Public Employees' Retirement System (PERS) who retire with less than 25 years of service credit from an employer that participates in the SEHBP.
- Full-time members of the TPAF and school board or county college employees enrolled in the PERS who retire with 25 years or more of service credit in one or more State or locally-administered retirement systems or who retire on a disability retirement, even if their employer did not cover its employees under the SEHBP. This includes those who elect to defer retirement with 25 or more years of service credit in one or more State or locally-administered retirement systems (see "Aggregate of Pension Membership Service Credit".)
- Full-time members of the TPAF or PERS who retire from a board of education, vocational/technical school, or special services commission; maintain participation in the health benefits plan of their former employer; and are eligible for and enrolled in Medicare Parts A and B. A qualified retiree may enroll at retirement or when he or she becomes eligible for Medicare.
- Participants in the Alternate Benefit Program (ABP) eligible for the SEHBP who retire with at least 25 years of credited ABP

service or those who are on a long term disability and begin receiving a monthly lifetime annuity immediately following termination of employment.

- Part-time faculty at institutions of higher education that participate in the SEHBP if enrolled in the SEHBP at the time of retirement.

Eligibility for SHBP or SEHBP membership for the individuals listed in this section is contingent upon meeting two conditions:

1. You must be immediately eligible for a retirement allowance from a State- or locally-administered retirement system (except certain employees retiring from a school board or community college); and
2. You were a full-time employee and eligible for employer-paid medical coverage immediately preceding the effective date of your retirement (if you are an employee retiring from a school board or community college under a deferred retirement with 25 or more years of service, you must have been eligible at the time you terminated your employment), or a part-time State employee or part-time faculty member who is enrolled in the SHBP or SEHBP immediately preceding the effective date of your retirement. This means that if you allow your active coverage to lapse (i.e. because of a leave of absence, reduction in hours, or termination of employment) prior to your retirement or you defer your retirement for any length of time after leaving employment; you will lose your eligibility for Retired Group health coverage. (This does not include former full-time employees enrolled in TPAF and PERS board of education or county college who retire with 25 or more years of service).

Note

Note: If you continue group coverage through COBRA (see the "COBRA" section)— or as a dependent under other coverage through a public employer — until your retirement becomes effective, you will be eligible for retired coverage under the SHBP or SEHBP.

Otherwise qualified employees whose coverage is terminated prior to retirement but who are later approved for a disability retirement will be eligible for Retired Group coverage beginning on the employee's retirement date. If the approval of the disability retirement is delayed, coverage shall not be retroactive for more than one year.

Aggregate of Pension Membership Service Credit

Upon retirement, a full-time State employee, board of education, or county college employee who has 25 years or more of service credit, is eligible for State-paid health benefits under the SHBP or SEHBP; subject to the applicable retiree contribution, if any. A full-time employee of a local government who has 25 years or more of service credit whose employer participates in the SHBP and has chosen to provide post-retirement medical coverage to its retirees is eligible for employer-paid health benefits under the SHBP. A retiree eligible for the SHBP or SEHBP may receive this benefit if the 25 years of service credit is from one or more State or locally-administered retirement systems and the time credited is nonconcurrent.

For PERS or TPAF members, Out-of-State Service, U.S. Government Service, or service with a bi-state or multi-state agency, requested for purchase after November 1, 2008, cannot be used to qualify for any State-paid or employer-paid health benefits in retirement.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Chapter 334 domestic partners (described below) and the Medicare requirements.

Chapter 334, P.L. 2005, provides that retirees from local entities (municipalities, counties, boards of education, and county colleges) whose employers do not participate in the in SHBP or SEHBP, but who become eligible for SHBP or SEHBP coverage at retirement, may also enroll a registered same-sex domestic partner as a covered dependent provided that the former employer's plan includes domestic partner coverage for employees.

Multiple Coverage under the SHBP/SEHBP is Prohibited

State statute specifically prohibits two members who are each enrolled in SHBP/SEHBP plans from covering each other. Therefore, an eligible individual may only enroll in the SHBP/SEHBP as an employee or retiree, or be covered as a dependent. Eligible children may only be covered by one participating subscriber. For example, a husband and wife both have coverage based on their employment and have children eligible for coverage. One may choose Family coverage, making the spouse and children the dependents and ineligible for any other SHBP/SEHBP coverage; or one may choose Single coverage and the spouse may choose Parent and Child(ren) coverage.

Enrolling in Retired Group Coverage

The Health Benefits Bureau is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in Retired Group coverage. Early filing for retirement is recommended to prevent any lapse of coverage or delay of eligibility.

If you do not submit a *Retired Coverage Enrollment Application* at the time of retirement, you will not generally be permitted to enroll for coverage at a later date. See Fact Sheet #11, Enrolling for Health Benefits Coverage When You Retire, for more information. If you believe you are eligible for Retired Group coverage and do not receive an offering letter by the date of your retirement, please contact the Division of Pensions and Benefits, Office of Client Services at **(609) 292-7524** or send an e-mail to: **pensions.nj@treas.state.nj.us**.

Additional restrictions and/or requirements may apply when enrolling for Retired Group coverage. Be sure to carefully read the "Retiree Enrollment" section of the **Summary Program Description**.

Medicare Parts A and B

IMPORTANT: A Retired Group member and/or dependent spouse, civil union partner, eligible same-sex domestic partner, or child who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP or SEHBP Retired Group coverage.

You will be required to submit documented evidence of enrollment in Medicare Part A and Part B when you or your dependent becomes eligible for that coverage. Acceptable documentation includes a photocopy of the Medicare card showing both Part A and Part B enrollment, or a letter from Medicare indicating the effective dates of both Part A and Part B coverage. Send your evidence of enrollment to the **Health Benefits Bureau, Division of Pensions and Benefits, PO Box 299, Trenton, New Jersey 08625-0299 or fax it to (609) 341-3407.** If you do not submit

evidence of Medicare coverage under both Part A and Part B, you and/or your dependents will be terminated from coverage. Upon submission of proof of full Medicare coverage, your Retired Group coverage will be reinstated by the Health Benefits Bureau on a prospective basis.

Medicare Part D

If you are enrolled in the Retired Group of the SHBP/SEHBP and eligible for Medicare, you will be automatically enrolled in Medicare Part D and the Medicare Prescription Plan.

Important: If you decide not to be enrolled in the Medicare Prescription Plan, you will lose your prescription drug benefits provided by the SEHBP/SHBP. However, your medical benefits will continue. In order to waive the Medicare Prescription Plan, you must enroll in another Medicare Part D plan. To request that you not be enrolled, you must submit a *Retired Change of Status Application* waiving your prescription drug coverage.

Medicare Eligibility

A member may be eligible for Medicare for the following reasons:

Medicare Eligibility by Reason of Turning Age 65

A member (the retiree or covered spouse/partner) is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if he or she is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The retired group health plan is not considered a secondary plan under the Aetna Medicare Advantage plans. The Aetna Medicare Advantage plan does not coordinate with original Medicare. For more information on your Aetna Medicare Advantage HMO or PPO ESA plans, please refer to the plan documents that are sent to you as a member directly or the high level information located on **www.aetnastatenj.com**.

Medicare Eligibility by Reason of Disability

A member (the retiree or covered spouse/partner or dependent) who is under age 65 is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits or 24 months.

Medicare Eligibility by Reasons of End Stage Renal Disease

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member (the retiree or covered spouse/partner or dependent) who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse/partner).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The rules listed above, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time. As of January 1, 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the Medicare eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of benefits period

During the "coordination of benefits" period, **Medicare is secondary to the group health plan coverage only if you have ESRD prior to becoming Medicare eligible due to age.** If you have ESRD and obtained Medicare prior to being declared as having ESRD, you will remain in the Aetna Medicare Advantage plan you are enrolled in. Should you have obtained Medicare due to ESRD, then during you coordination period you will be placed in a corresponding plan that coordinates with Original Medicare. When that coordination period ends, you will be placed back on your respective Medicare Advantage plan. Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD, the coordination of benefits period is 30 months.

How to File a Claim If You Are Eligible for Medicare

For all Aetna Medicare Plan (HMO) members, claims are submitted directly to Aetna, not to Medicare. Your provider will bill Aetna directly, using the claims address on the back of your Aetna Medicare Plan (HMO) ID card.

Members of the Aetna Medicare Plan (HMO) will receive one Explanation of Benefits from Aetna. Members do not need to coordinate with Medicare or submit any additional information. However, if a claim is submitted to Medicare in error, Medicare will deny the claim. In this case, the member can submit this claim information to Aetna (using the claims address on the back of the Aetna Medicare Plan (HMO) ID card) for processing under the Aetna Medicare Plan (HMO). Any questions can be directed to Aetna Medicare Plan (HMO) Member Services at **1-866-234-3129**.

For all other Aetna members, follow the procedure listed below that applies to you when filing your claim.

New Jersey Physicians or Providers:

- You should provide the physician or provider with your identification number. This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."
- The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.
- After Medicare has taken action, you will receive an *Explanation of Benefits* statement from Medicare.
- If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to Aetna for their consideration in processing supplementary coverage benefits."

If the statement shown above does not appear on the *Explanation of Benefits*, please attach a completed Aetna claim form, to a copy of the itemized bill from your physician or provider along with a copy of the Medicare Explanation of Benefits, and submit it to Aetna using the address on the back of your ID card.

Out-Of-State Physicians or Providers:

- The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.
- When you receive your *Explanation of Benefits* from Medicare please attach a completed Aetna claim form, attach a copy of the itemized bill from your physician or provider and submit it to Aetna using the address on the back of your ID card.

Medicare Estimation

If you or your covered dependent do not enroll in Medicare Parts A and/or B coverage when you become eligible, you may pay more of your health care expenses. Aetna will process your claims as follows:

- Aetna will estimate the Medicare benefits that would have been available to you, if enrolled in Medicare Part A and/or Part B. When Aetna receives a claim that would be covered by Medicare Parts A and/or B, we will estimate what Medicare Parts A and/or B would pay for your medical services if you were enrolled in Medicare Parts A and/or B.
- Aetna will calculate your benefits under this plan after taking into consideration the estimated Medicare payments to your providers.
- You will be responsible for the amount that Aetna estimates Medicare would have paid, in addition to coinsurance, deductibles and/or copayments.

For more information about Medicare enrollment, or to enroll, contact Social Security Administration.

- Call **1-800-772-1213** (TTY: 1-800-325-0778)
- Visit **socialsecurity.gov**. Under certain conditions, you may be able to enroll online.
- Call or visit your local office. Locations listed in your telephone directory.

COBRA Coverage

Continuing Coverage When It Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see "Duration of COBRA Coverage", and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is not subtracted from your COBRA eligibility period.

Under COBRA, you may elect to enroll in any or all of the coverages you had as an active employee or dependent (health, prescription, dental, and vision), and you may change your health or dental plan when enrolling in COBRA. You may also elect to cover the same dependents that you covered while an active employee, or delete dependents from coverage — however, you cannot add dependents who were not covered while an employee except during the annual Open

Enrollment period (see below) or unless a "qualifying event" (marriage, birth or adoption of a child, etc.) occurs within 60 days of the COBRA event.

Open Enrollment – COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any medical, dental, or prescription drug coverage during the Annual Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the Annual Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission make changes to any benefit plan available to active employees and/or retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).
- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce, legal separation, dissolution of civil union or same-sex domestic partnership (makes spouse or partner ineligible for further dependent coverage).
- Loss of a dependent child's eligibility through the attainment of age 26.
- The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

Note

Employees who at retirement are eligible to enroll for coverage in the Retired Group of the SHBP and SEHBP cannot enroll for health benefits coverage under COBRA. The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

DURATION OF COBRA COVERAGE

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of termination of employment, a reduction in hours, or a leave of absence. Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within

the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first. COBRA coverage may be purchased by a dependent for up to 36 months if he or she becomes eligible because of your death, divorce, dissolution of a civil union or domestic partnership, or a child becomes ineligible upon attaining age 26, or because you elected Medicare as your primary coverage.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities under COBRA

The COBRA law requires employers to:

- Notify you and your dependents of the COBRA provisions within 90 days of when you and your dependents are first enrolled;
- Notify you, your spouse, civil union partner, or eligible same-sex domestic partner, and your children of the right to purchase continued coverage within 14 days of receiving notice that there has been a COBRA qualifying event that causes a loss of coverage;
- Send the COBRA Notification Letter and a COBRA Application within 14 days of receiving notice that a COBRA qualifying event has occurred;
- Notify the Health Benefits Bureau of the Division of Pensions and Benefits within 30 days of the loss of an employee's coverage; and
- Maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- Notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, dissolution of a civil union or domestic partnership, or death has occurred, or that your child has reached age 26 — notification must be given within 60 days of the date the event occurred;
- File a COBRA Application within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- Pay the required monthly premiums in a timely manner; and
- Pay premiums, when billed, retroactive to the date of group coverage termination.

Failure to Elect COBRA Coverage

In considering whether to elect continuation of coverage under COBRA, an eligible employee, retiree, or dependent (also known as a "qualified beneficiary" under COBRA law) should take into account that a failure to continue group health coverage will affect future rights under federal law.

First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. The election of continuation of coverage under COBRA may help you to bridge such a gap. (If, after enrolling in COBRA you obtain new coverage which has a pre-existing condition clause, you may continue your COBRA enrollment to cover the condition excluded by the pre-existing condition clause.)

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition

exclusions if you do not continue coverage under COBRA for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days of the date your group coverage ends. You will also have the same special enrollment right at the end of the COBRA coverage period if you get the continuation of coverage under COBRA for the maximum time available to you.

Termination of COBRA Coverage

Your COBRA coverage will end when any of the following situations occur:

Your eligibility period expires;

- You fail to pay your premiums in a timely manner;
- After the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- You voluntarily cancel your coverage;
- Your employer drops out of the SHBP and SEHBP;

You become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year- to-year basis.

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A Certification of Coverage form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resources office, should you terminate your coverage.

HIPAA Privacy

The State Health Benefits Program and School Employees' Health Benefits Program make every effort to safeguard the health information of its members and comply with the privacy provisions of HIPAA, which requires that health plans maintain the privacy of any personal information relating to its members' physical or mental health.

Termination for Cause

Your coverage and the coverage of your dependents under this Plan may be terminated for cause. "For cause" is defined as:

- **Untenable relationship:** After reasonable efforts, Aetna and/or the Plan's participating providers are unable to establish and maintain a satisfactory provider-patient relationship with the member, or the member repeatedly acts in a manner which is verbally or physically abusive.
- **Failure to make copayments:** The member fails to make required copayments or any other payment which he or she is required to pay.

- **Misuse of identification card:** The member permits any person to use his or her Aetna identification card.
- **Furnishing incorrect or incomplete information:** The member willfully furnishes incorrect or incomplete information in a statement made for the purpose of enrolling in or obtaining benefits from the Plan.
- **Non-compliance with your physician's plan of treatment:** You have the right to refuse any drugs, treatment or other procedure offered to you by a participating provider, and to be informed by your physician of the medical consequences of your refusal of any drugs, treatment or procedure. Aetna and your Primary Care Physician will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended plan of treatment, the Plan will not be responsible for the costs of further treatment for that condition, and you will be so notified. You may use the appeal process to have your case reviewed.
- **Misconduct:** The member abuses the system, including, but not limited to, theft, fraud, damage to the property of a participating provider or forgery of drug prescriptions.

No benefits, other than for emergency care, will be provided to you and your family members as of 31 days after the date notice of termination is given to you by the State Health Benefits Commission.

Any termination for cause is subject to review in accordance with the Plan's appeal process. If an appeal to Aetna is denied, you may appeal to the State Health Benefits Commission. If the Commission governing your coverage upholds the termination, you must change your coverage by completing a Health Benefits Program Application to enroll in another health plan. Benefits under this Plan end when your application is received and processed by the Division of Pensions and Benefits, Health Benefits Bureau. If the Commission overrules the decision to terminate, full coverage will be restored retroactively.

Health Care Fraud

Health care fraud is an intentional deception or misrepresentation that results in an unauthorized benefit to a member or to some other person. Any individual who willfully and knowingly engages in an activity intended to defraud the SHBP will face disciplinary action that could include termination of employment and may result in prosecution. Any member who receives monies fraudulently from a health plan will be required to fully reimburse the plan.

How the Plan Works

How the Plan Works

Plan participants have access to a network of participating Primary Care Physicians (PCPs), specialists and hospitals that meet Aetna's requirements for quality and service. These providers are independent physicians and facilities that are monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards and ongoing training. The Aetna HMO's cover in-network benefits only except for in an emergency situation.

Each participant in the Plan must select a Primary Care Physician (PCP) when they enroll. Your PCP serves as your guide to care in today's complex medical system and will help you access appropriate care.

The Primary Care Physician

As a participant in the Plan, you will become a partner with your participating PCP in preventive medicine. You will need to elect a Primary Care Physician upon entering the Aetna HMO plan. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when medically necessary, your PCP will refer you to other doctors or facilities for treatment. The referral is important because it is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment. Except for PCP, direct access and emergency services, you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment.

Participating specialists are required to send reports back to your PCP to keep your PCP informed of any treatment plans ordered by the specialist.

Note

If you determine there is a need to change your Primary Care Physician to another PCP, please contact the Aetna Member Services phone number on the back of your ID card and alert them to your required change. If you do not alert Aetna to the change in your primary care physician, you may be responsible for additional charges.

Primary and Preventive Care

Your PCP can provide preventive care and treat you for illnesses and injuries. The Plan covers routine physical exams, well-baby care, immunizations and allergy shots provided by your PCP. You may also obtain routine vision exams and gynecological exams from participating providers without a referral from your PCP. You are responsible for the copayment shown in the "Schedule of Benefits."

Specialty and Facility Care

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. Except for those benefits described in this booklet as direct access benefits and emergency care, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.

When your PCP refers you to a participating specialist or facility for covered services, you will be responsible for the copayment shown in the "Schedule of Benefits."

For inpatient expenses and surgery performed in an outpatient facility, you must pay a portion of the covered expenses you incur. Your share of covered expenses is called your coinsurance. Once your copayments and coinsurance amounts reach the annual out-of-pocket maximum, the Plan pays 100% of your covered expenses for the remainder of that calendar year.

To avoid costly and unnecessary bills, follow these steps:

- Consult your PCP first when you need routine medical care. If your PCP deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Plan. For direct access benefits, you may contact the participating provider directly, without a referral.
- Certain services require both a referral from your PCP and prior authorization from Aetna. Your PCP is responsible for obtaining authorization from Aetna for in-network covered services.
- Review the referral with your PCP. Understand what specialist services are being recommended and why.
- Present the referral to the participating provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. Without the referral, you are responsible for payment for these services.
- If it is not an emergency and you go to a doctor or facility without your PCP's prior written or electronic referral, you must pay the bill yourself.
- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by Aetna in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

REMEMBER: You cannot request referrals after you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from Aetna (when applicable) before seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems (IDS) or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by non-affiliated physicians or facilities. Services provided by non-affiliated providers may require prior authorization from Aetna and/or the IDS or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Provider Information

You may obtain, without charge, a listing of network providers from your Plan Administrator, or by calling the toll-free Member Services number on your ID card.

It is easy to obtain information about providers in Aetna's network using the Internet. With DocFind® you can conduct an online search for participating doctors, hospitals and other providers. To use DocFind, go to **AetnaStateNJ.com** and click on "Find a Doctor". Select the appropriate provider category and follow the instructions provided to select a provider based on specialty, geographic location and/or hospital affiliation.

Your ID Card

When you join the Plan, you and each enrolled member of your family receive a member ID card. Your ID card lists the telephone number of the Aetna PCP you have chosen. If you change your PCP, you will automatically receive a new card displaying the change.

Always carry your ID card with you. It identifies you as a Plan participant when you receive services from participating providers or when you receive emergency services at nonparticipating facilities. If your card is lost or stolen, please notify Aetna immediately.

Schedule of Benefits – Aetna HMO Plan

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Plan Features	In-Network Benefit
Annual Out of Pocket Limit	
Individual	$6,320 per Calendar Year (Active Employees Local Government and Education) $6,549 per Calendar Year (Early Retirees Local Government) $6,489 per Calendar Year (Early Retirees Local Education)
Family	$12,640 per Calendar Year (Active Employees Local Government and Education) $13,098 per Calendar Year (Early Retirees Local Government) $12.978 per Calendar Year (Early Retirees Local Education)
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$10 copay per visit
After Hours/Home Visits/Emergency Visits	$15 copay per visit
Routine Physical Examinations	
Routine Physical Examinations	Covered at 100% per visit No copay applies
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician by logging onto the Aetna Navigator website at Aetna.com or call the number on the back of your ID card.

Plan Features	In-Network Benefit
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit
Preventive Care Immunizations	
Performed in a facility or physician's office	Covered at 100% per visit No copay applies
Well Woman Preventive Visits	
Office Visits	Covered at 100% per visit No copay applies
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings	
Outpatient	No Calendar Year deductible applies.
Lung Cancer Screening Maximum 1 screening every calendar year Covered from age 55 years & older	Covered at 100% per visit No copay applies
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician by logging onto the Aetna Navigator website at Aetna.com or call the number on the back of your ID card.

Plan Features	In-Network Benefit
Screening & Counseling Services	
Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	Covered at 100% per visit No copay applies
Obesity Maximum Visits per Calendar Year visits (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services	
Female Contraceptive Counseling Services -Office Visits.	100% no copay per visit
Family Planning Services - Female Voluntary Sterilization	
Inpatient	100% no copay per visit
Outpatient	100% no copay per visit

Plan Features	In-Network Benefit
Family Planning Services – Female Contraceptives	
Female contraceptives that are generic prescription drugs • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No deductible applies
Female contraceptive devices	100% per prescription or refill No deductible applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies
Breast Pumps & Supplies	Covered at 100% per item No copay applies
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No Calendar Year deductible applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% per prescription or refill No Calendar Year deductible applies.

Plan Features	In-Network Benefit
Vision and Hearing Care	
Routine Eye Examinations direct access no referral) to participating providers for periodic routine exams	$10 copay per visit 1 visit per calendar year
Hearing Exam by an Audiologist (Children through age 15)	$10 copay per visit 1 visit per calendar year
Hearing Aids (Children through age 15) Hearing supply maximum of $1,000 per ear per 24 months"	$1,000 per ear
Nutritional Support	
Covers special formulas and low protein food products prescribed by a physician and certified medically necessary for certain conditions, not subject to any calendar year or lifetime maximum. 100% No deductible no copay for infant formula	Covered at 100% No copay
Specialty and Outpatient Care	
Specialist Office Visits	$10 copay per visit
Prenatal Care - for the first OB visit	100% no deductible after a $10 copay
Walk-In Clinic Visits	$10 copay per visit
Infertility Services	Copay based on where service is provided
Advanced Reproductive Technology Limited to 4 egg retrievals per lifetime	$10 copay per visit

Plan Features	In-Network Benefit
Allergy Testing and Treatment Routine injections at PCP's or Specialist office	$10 copay per visit with physician encounter No copay when there is no physician encounter
Outpatient Facility Visits	
When rendered in home office or outpatient facility Chemotherapy	100% no copay per visit
Radiation Therapy	100% no copay per visit
Infusion Therapy* *No copay when done in conjunction with Chemotherapy and a cancer diagnosis	$10 copay per visit
Cardiac Rehabilitation	$10 copay per visit
X-rays and Lab Tests	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit

Plan Features	In-Network Benefit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT);and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Outpatient Therapy	
Outpatient Therapy (speech, occupational, physical) Subject to medical necessity review	$10 copay per visit
Spinal Manipulation	$10 copay per visit Limited to 20 visits per calendar year and subject to medical necessity
Acupuncture benefit Only covered in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Habilitation Therapy Services	
Outpatient physical, occupational, and speech therapy	$10 copay per visit
Clinical Trial Therapies	
Clinical Trial Therapies (Experimental or Investigational Treatment for Clinical Trials Only)	Payable in accordance with the type of expense incurred and the place where service is provided.
Clinical Trial Therapies (Routine Patient Costs)	Payable in accordance with the type of expense incurred and the place where service is provided.

Plan Features	In-Network Benefit
Home Health Care	
Home Health Care Unlimited visits per Calendar Year	100% no copay per visit
Private Duty Nursing	100% no copay per visit
Hospice Care	
Hospice Care Unlimited visits per Calendar Year	100% no copay per visit
Medical Injectable Medications	
Medical Injectable Medications	$10 copay per prescription*
*Self-Injectable Medications are not covered under the medical plan. Please reach out to your pharmacy carrier for more details on self-injectable medications.	
Durable Medical Equipment (DME)	
Durable Medical Equipment (DME)	100% (of the cost) after $100 deductible
Diabetic Supplies*	Payable in accordance with the type of expense incurred and the place where service is provided.
Important Note: There are specific diabetic supplies that are covered under the medical plan such as blood glucose monitors and monitor supplies (does not include blood glucose test strips), pump & pump supplies, diabetic shoes and orthotic devices. Disposable supplies are covered under your prescription drug plan. Please refer to your Prescription Drug guidebook for more information on diabetic disposable supplies.	
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	100% (of the cost) after $100 deductible or $10 copay for specific services noted in the State of New Jersey mandate. Some prostheses must be approved in advance by Aetna
Important Note: The provider's reimbursement for prosthetic and orthotic devices shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.	

Plan Features	In-Network Benefit
Parenteral/Enteral Nutrition and Related Services	Covered at 100%, no copay
Wigs	100% (of the cost) after $100 deductible up to $500 Maximum every 24 months. Only covered if they are furnished in connection with hair loss resulting from treatment of disease by radiation or chemicals; alopecia universal is (totalis); alopecia areata, services are always covered regardless of whether a facility is participating or not.
Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	Covered at 100%
Outpatient Morbid Obesity Surgery	Covered at 100%
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	100% no copay per admission
Skilled Nursing Facilities Maximum of 120 days per Calendar Year	100% no copay per admission
Hospice Facility	100% no copay per admission
Surgery and Anesthesia	
Inpatient Surgery	Covered at 100%, no copay
Outpatient Surgery Performed at a Hospital Outpatient Facility	100% no copay per visit
Outpatient Surgery Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit

Plan Features	In-Network Benefit
Autism Spectrum Disorder	
Autism Physical Therapy, Occupational Therapy and Speech Therapy	$10 copay per visit
Autism - Behavioral Therapy	$10 copay per visit
Autism - Applied Behavior Analysis	$10 copay per visit
Mental Disorders	
During a Hospital Confinement	100% no copay per admission
During a Residential Treatment Facility Confinement	100% no copay per admission
Outpatient Mental Disorders Visits	$10 copay per visit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$10 copay per visit

Plan Features	In-Network Benefit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies
Substance Abuse	
Detoxification and Rehabilitation During a Hospital confinement	100% no copay per admission
During a Residential Treatment Facility confinement	100% no copay per admission
Outpatient Substance Abuse Visits Detoxification	$10 copay per visit
Rehabilitation (Including Partial Hospitalization and Intensive Outpatient Programs)	$10 copay per visit

Plan Features	In-Network Benefit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations.	$10 copay per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies

Plan Features	In-Network Benefit
Maternity	
Mother	100% per admission
Newborn*	100% per admission
* Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered.	
Emergency Care	
Hospital Emergency Room or Outpatient Department	$85 copay per visit (Local Government Active and Early Retirees) $35 copay per visit (Local Education Active and Early Retirees)
Children through age 18	$35 copay per visit
With written referral	$35 copay per visit
Urgent Care Facility	$10 copay per visit
Ambulance	100% no copay per trip

Schedule of Benefits – Aetna HMO Plan (State only)

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Plan Features	In-Network Benefit
Annual Out of Pocket Limit	
Individual	$6,320 per Calendar Year
Family	$12,640 per Calendar Year
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$15 copay per visit
After Hours/Home Visits/Emergency Visits	$20 copay per visit
Routine Physical Examinations	The Plan pays 100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit
Preventive Care Immunizations Performed in a facility or physician's office	The Plan pays 100% per visit No deductible applies.

Plan Features	In-Network Benefit
Well Woman Preventive Visits Office Visits	The Plan pays 100% per visit No copay or deductible applies.
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings	
Outpatient	No Calendar Year deductible applies.
Lung Cancer Screening Maximum 1 screening every calendar year Covered from age 55 years & older	Covered at 100% per visit No copay applies
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Screening & Counseling Services	
Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	The Plan pays 100% per visit No copay or deductible applies.
Obesity Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	

Plan Features	In-Network Benefit
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services	
Female Contraceptive Counseling Services -Office Visits.	100% no copay per visit
Family Planning Services – Female Contraceptives	
Female contraceptives that are generic prescription drugs • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No deductible applies
Female contraceptive devices	100% per prescription or refill No deductible applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies
Family Planning Services - Female Voluntary Sterilization	
Inpatient	100% no copay per visit
Outpatient	100% no copay per visit
Breast Pumps & Supplies	Covered at 100% per item No copay applies

Plan Features	In-Network Benefit
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
Vision and Hearing Care	
Routine Eye Examinations direct access (no referral) to participating providers for periodic routine exams	$15 copay per visit 1 visit per calendar year
Hearing Exam by an Audiologist (Children) Through age 15	$15 copay 1 visit per calendar year
Hearing Aids (Children) Through age 15 Hearing supply maximum of $1,000 per ear per 24 months	100% no copay per item No Calendar Year deductible applies.
Nutritional support	
Covers special formulas and low protein food products prescribed by a physician and certified medically necessary for certain conditions, not subject to any calendar year or lifetime maximum. 100% No deductible no copay for infant formula	Covered at 100% No copay

Plan Features	In-Network Benefit
Specialty and Outpatient Care	
Specialist Office Visits	$15 copay per visit
Prenatal Care - for the first OB visit	100% no deductible after a $15 copay
Walk-In Clinic Visits	$15 copay per visit
Infertility Services	Copay based on where service is provided
Advanced Reproductive Technology Limited to 4 egg retrievals per lifetime	$15 copay per visit
Allergy Testing and Treatment Routine injections at PCP's or Specialist office	$15 copay per visit with physician encounter 100% no copay when there is no physician encounter
Outpatient Facility Visits	
When rendered in home office or outpatient facility	
Chemotherapy	100% no copay per visit
Radiation Therapy	100% no copay per visit
Infusion Therapy* *No copay when done in conjunction with Chemotherapy and a cancer diagnosis	$15 copay per visit
Cardiac Rehabilitation	$15 copay per visit
X-rays and Lab Tests	
Performed at a Hospital Outpatient Facility	100% no copay per visit

Plan Features	In-Network Benefit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT);and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Outpatient Therapy	
Outpatient Therapy (speech, occupational, physical)	$15 copay per visit Subject to medical necessity review
Spinal Manipulation	$15 copay per visit Limited to 20 visits per calendar year and subject to medical necessity
Acupuncture benefit Only covered in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Habilitation Therapy Services	
Outpatient physical, occupational, and speech therapy	$15 copay per visit

Plan Features	In-Network Benefit
Clinical Trial Therapies	
Clinical Trial Therapies (Experimental or Investigational Treatment for Clinical Trials Only)	Payable in accordance wiht the type of expense incurred and the place where service is provided.
Clinical Trial Therapies (Routine Patient Costs)	Payable in accordance wiht the type of expense incurred and the place where service is provided.
Home Health Care	
Home Health Care Unlimited visits per Calendar Year	100% no copay per visit
Private Duty Nursing	100% no copay per visit
Hospice Care	
Hospice Care Unlimited visits per Calendar Year	100% no copay per visit
Medical Injectable Medications	$15 copay per prescription*
*Self-Injectable Medications are not covered under the medical plan. Please reach out to your pharmacy carrier for more details on self-injectable medications.	
Durable Medical Equipment (DME)	
Durable Medical Equipment (DME)	100% (of the cost) after $100 deductible
Diabetic Supplies*	Payable in accordance wiht the type of expense incurred and the place where service is provided.
Important Note: There are specific diabetic supplies that are covered under the medical plan such as blood glucose monitors and monitor supplies (does not include blood glucose test strips), pump & pump supplies, diabetic shoes and orthotic devices. Disposable supplies are covered under your prescription drug plan. Please refer to your Prescription Drug guidebook for more information on diabetic disposable supplies.	

Plan Features	In-Network Benefit
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	100% (of the cost) after $100 deductible or % $15 copay for specific services noted in the State of New Jersey mandate. Some prostheses must be approved in advance by Aetna
Important Note: The provider's reimbursement for prosthetic and orthotic devices shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.	
Parenteral/Enteral Nutrition and Related Services	100% no copay
Wigs	100% (of the cost) after $100 deductible up to $500 Maximum every 24 months. Only covered if they are furnished in connection with hair loss resulting from treatment of disease by radiation or chemicals; alopecia universal is (totalis); alopecia areata, services are always covered regardless of whether a facility is participating or not.
Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	100% per service
Outpatient Morbid Obesity Surgery	100% per service
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	100% no copay per admission
Skilled Nursing Facilities Maximum of 120 days per Calendar Year	100% no copay per admission
Hospice Facility	100% no copay per admission

Plan Features	In-Network Benefit
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Autism Spectrum Disorder	
Autism Physical Therapy, Occupational Therapy and Speech Therapy	$15 copay per visit
Autism - Behavioral Therapy	$15 copay per visit
Autism - Applied Behavior Analysis	$15 copay per visit
Mental Disorders	
During a Hospital Confinement	100% no copay per admission
During a Residential Treatment Facility Confinement	100% no copay per admission
Outpatient Mental Disorders Visits	$15 copay per visit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$15 copay per visit

Plan Features	In-Network Benefit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies
Substance Abuse	
Detoxification and Rehabilitation	
During a Hospital confinement	100% no copay per admission
During a Residential Treatment Facility confinement	100% no copay per admission
Outpatient Substance Abuse Visits	
Detoxification	$15 copay per visit
Rehabilitation Including Partial Hospitalization and Intensive Outpatient Programs	$15 copay per visit

Plan Features	In-Network Benefit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$15 copay per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies

Plan Features	In-Network Benefit
Maternity	
Mother	100% per admission
Newborn*	100% per admission
*Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered.	
Emergency Care	
Hospital Emergency Room or Outpatient Department	$100 copay per visit
Children through age 18	$50 copay per visit
With written referral	$50 copay per visit
Urgent Care Facility	$15 copay per visit
Ambulance	100% no copay per trip

Schedule of Benefits – Aetna HMO $15/$25 Plan

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Plan Features	In-Network Benefit
Annual Out of Pocket Limit	
Individual	$6,320 per Calendar Year (Active Employees Local Government and Education) $6,549 per Calendar Year (Early Retirees Local Government) $6,489 per Calendar Year (Early Retirees Local Education)
Family	$12,640 per Calendar Year (Active Employees Local Government and Education) $13,098 per Calendar Year (Early Retirees Local Government) $12.978 per Calendar Year (Early Retirees Local Education)
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$15 copay per visit
After Hours/Home Visits/Emergency Visits	$20 copay per visit
Routine Physical Examinations	The Plan pays 100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit

Plan Features	In-Network Benefit
Preventive Care Immunizations Performed in a facility or physician's office	The Plan pays 100% per visit No deductible applies.
Well Woman Preventive Visits Office Visits	The Plan pays 100% per visit No copay or deductible applies.
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings	
Outpatient	No Calendar Year deductible applies.
Lung Cancer Screening Maximum 1 screening every calendar year Covered from age 55 years & older	Covered at 100% per visit No copay applies
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Screening & Counseling Services	
Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	The Plan pays 100% per visit No copay or deductible applies.
Obesity Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	

Plan Features	In-Network Benefit
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services	
Female Contraceptive Counseling Services - Office Visits.	100% no copay per visit
Family Planning Services - Female Voluntary Sterilization	
Inpatient	100% no copay per visit
Outpatient	100% no copay per visit
Breast Pumps & Supplies	Covered at 100% per item No copay applies
Family Planning Services – Female Contraceptives	
Female contraceptives that are generic prescription drugs • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No deductible applies
Female contraceptive devices	100% per prescription or refill No deductible applies

Plan Features	In-Network Benefit
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
Vision and Hearing Care	
Routine Eye Examinations direct access (no referral) to participating providers for periodic routine exams	$25 copay per visit 1 visit per calendar year
Hearing Exam by an Audiologist (Children through age 15)	$25 copay per visit 1 visit per calendar year
Hearing Aids (Children through age 15) Hearing supply maximum of $1,000 per ear per 24 months	100% no copay per item No Calendar Year deductible applies.

Plan Features	In-Network Benefit
Nutritional Support	
Covers special formulas and low protein food products prescribed by a physician and certified medically necessary for certain conditions, not subject to any calendar year or lifetime maximum. 100% No deductible no copay for infant formula	Covered at 100% No copay
Specialty and Outpatient Care	
Specialist Office Visits	$25 copay per visit
Prenatal Care - for the first OB visit	100% no deductible after a $25 copay
Walk-In Clinic Visits	$15 copay per visit
Infertility Services	Copay based on where service is provided
Advanced Reproductive Technology Limited to 4 egg retrievals per lifetime	$25 copay per visit
Allergy Testing and Treatment Routine injections at PCP's or Specialists office	$15 PCP or $25 Specialist copay per visit with physician encounter 100% no copay when there is no physician encounter
Outpatient Facility Visits	
When rendered in home office or outpatient facility	
Chemotherapy	100% no copay per visit
Radiation Therapy	100% no copay per visit

Plan Features	In-Network Benefit
Infusion Therapy* *No copay when done in conjunction with Chemotherapy and a cancer diagnosis	$25 copay per visit
Cardiac Rehabilitation	$25 copay per visit
X-rays and Lab Tests	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT);and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Outpatient Therapy	
Outpatient Therapy (speech, occupational, physical)	$25 copay per visit Subject to medical necessity review
Spinal Manipulation	$25 copay per visit Limited to 20 visits per calendar year and subject to medical necessity

Plan Features	In-Network Benefit
Acupuncture benefit Only covered in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Habilitation therapy service	
Outpatient physical, occupational, and speech therapy	$25 copay per visit
Clinical Trial Therapies	
Clinical Trial Therapies (Experimental or Investigational Treatment for Clinical Trials Only)	Payable in accordance with the type of expense incurred and the places where service is provided.
Clinical Trial Therapies (Routine Patient Costs)	Payable in accordance with the type of expense incurred and the places where service is provided.
Home Health Care	
Home Health Care Unlimited visits per Calendar Year	100% no copay per visit
Private Duty Nursing	100% no copay per visit
Hospice Care	
Hospice Care Unlimited visits per Calendar Year	100% no copay per visit
Medical Injectable Medications	
Medical Injectable Medications	$15 PCP or $25 Specialist copay per prescription*
*Self-Injectable Medications are not covered under the medical plan. Please reach out to your pharmacy carrier for more details on self-injectable medications.	

Plan Features	In-Network Benefit
Durable Medical Equipment (DME)	
Durable Medical Equipment (DME)	100% (of the cost) after $100 deductible
Diabetic Supplies*	Payable in accordance with the type of expense incurred and the place where service is provided.
Important Note: There are specific diabetic supplies that are covered under the medical plan such as blood glucose monitors and monitor supplies (does not include blood glucose test strips), pump & pump supplies, diabetic shoes and orthotic devices. Disposable supplies are covered under your prescription drug plan. Please refer to your Prescription Drug guidebook for more information on diabetic disposable supplies.	
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	100% (of the cost) after $100 deductible or $15 copay for specific services noted in the State of New Jersey mandate. Some prostheses must be approved in advance by Aetna
Important Note: The provider's reimbursement for prosthetic and orthotic devices shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.	
Parenteral/Enteral Nutrition and Related Services	100% no copay
Wigs	100% (of the cost) after $100 deductible up to $500 Maximum every 24 months. Only covered if they are furnished in connection with hair loss resulting from treatment of disease by radiation or chemicals; alopecia universal is (totalis); alopecia areata, services are always covered regardless of whether a facility is participating or not.
Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	100% per service
Outpatient Morbid Obesity Surgery	100% per service

Plan Features	In-Network Benefit
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	100% no copay per admission
Skilled Nursing Facilities Maximum of 120 days per Calendar Year	100% no copay per admission
Hospice Facility	100% no copay per admission
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Autism Spectrum Disorder	
Autism Physical Therapy, Occupational Therapy and Speech Therapy	$25 copay per visit
Autism - Behavioral Therapy	$25 copay per visit
Autism - Applied Behavior Analysis	$25 copay per visit
Mental Disorders	
During a Hospital Confinement	100% no copay per admission
During a Residential Treatment Facility Confinement	100% no copay per admission
Outpatient Mental Disorders Visits	$25 copay per visit.

Plan Features	In-Network Benefit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	25 copay per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies
Substance Abuse	
Detoxification and Rehabilitation	
During a Hospital confinement	100% no copay per admission
During a Residential Treatment Facility confinement	100% no copay per admission

Plan Features	In-Network Benefit
Outpatient Substance Abuse Visits	
Detoxification	$25 copay per visit
Rehabilitation Including Partial Hospitalization and Intensive Outpatient Programs	$25 copay per visit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$25 copay per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies

Plan Features	In-Network Benefit
Maternity	
Mother	100% per admission
Newborn*	100% per admission
*Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered	
Emergency Care	
Hospital Emergency Room or Outpatient Department	$100 copay per visit $75 copay per visit (Local Education Active and Early Retirees)
Children through age 18	$75 copay per visit
With written referral	$75 copay per visit
Urgent Care Facility	$25 copay per visit
Ambulance	100% no copay per trip

Schedule of Benefits – Aetna HMO $20/$30 Plan

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Plan Features	In-Network Benefit
Annual Out of Pocket Limit	
Individual	$6,320 per Calendar Year (Active Employees Local Government and Education) $6,549 per Calendar Year (Early Retirees Local Government) $6,489 per Calendar Year (Early Retirees Local Education)
Family	$12,640 per Calendar Year (Active Employees Local Government and Education) $13,098 per Calendar Year (Early Retirees Local Government) $12,978 per Calendar Year (Early Retirees Local Education)
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$20 copay per visit
After Hours/Home Visits/Emergency Visits	$25 copay per visit
Routine Physical Examinations	The Plan pays 100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit

Plan Features	In-Network Benefit
Preventive Care Immunizations Performed in a facility or physician's office	The Plan pays 100% per visit No deductible applies
Well Woman Preventive Visits Office Visits	The Plan pays 100% per visit No copay or deductible applies
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings	
Outpatient	No Calendar Year deductible applies.
Lung Cancer Screening Maximum 1 screening every calendar year Covered from age 55 years & older	Covered at 100% per visit No copay applies
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Screening & Counseling Services	
Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	The Plan pays 100% per visit No copay or deductible applies.
Obesity Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	

Plan Features	In-Network Benefit
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services	
Female Contraceptive Counseling Services - Office Visits	100% no copay per visit
Family Planning Services - Female Voluntary Sterilization	
Inpatient	100% no copay per visit
Outpatient	100% no copay per visit
Breast Pumps & Supplies	Covered at 100% per item No copay applies
Family Planning Services – Female Contraceptives	
Female contraceptives that are generic prescription drugs • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No deductible applies
Female contraceptive devices	100% per prescription or refill No deductible applies

Plan Features	In-Network Benefit
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
Vision and Hearing Care	
Routine Eye Examinations direct access (no referral) to participating providers for periodic routine exams	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit 1 visit per calendar year
Hearing Exam by an Audiologist (Children through age 15)	$20 copay 1 visit per calendar year
Hearing Aids (Children throug age 15) Hearing supply maximum of $1,000 per ear per 24 months"	100% no copay per item No Calendar Year deductible applies.

Plan Features	In-Network Benefit
Nutritional Support	
Covers special formulas and low protein food products prescribed by a physician and certified medically necessary for certain conditions, not subject to any calendar year or lifetime maximum. 100% No deductible no copay for infant formula	Covered at 100% No copay
Specialty and Outpatient Care	
Specialist Office Visits	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Prenatal Care - for the first OB visit	100% no deductible after a $30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Walk-In Clinic Visits	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Infertility Services	Copay based on where service is provided
Advanced Reproductive Technology Limited to 4 egg retrievals per lifetime	$30 copay per visit
Allergy Testing and Treatment Routine injections at PCP's or Specialist office	$20 PCP or $30 copay for adults and $20 copay for children up to the end of the year they turn 26 per visit with physician encounter 100% no copay when there is no physician encounter
Outpatient Facility Visits	
When rendered in home office or outpatient facility	
Chemotherapy	100% no copay per visit
Radiation Therapy	100% no copay per visit

Plan Features	In-Network Benefit
Infusion Therapy* *No copay when done in conjunction with Chemotherapy and a cancer diagnosis	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Cardiac Rehabilitation	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
X-rays and Lab Tests	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT);and Positron Emission Tomography (PET) Precertification required	100% no copay per visit
Outpatient Therapy	
Outpatient Therapy (speech, occupational, physical)	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit Subject to medical necessity review
Spinal Manipulation	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit Limited to 20 visits per calendar year and subject to medical necessity

Plan Features	In-Network Benefit
Acupuncture benefit Only covered in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Habilitation Therapy Service	
Outpatient physical, occupational, and speech therapy	$30 specialist copay for adults and $20 for children to the end of year they turn 26
Clinical Trial Therapies	
Clinical Trial Therapies (Experimental or Investigational Treatment for Clinical Trials Only)	Payable in accordance with the type of expense incurred and the places where service is provided.
Clinical Trial Therapies (Routine Patient Costs)	Payable in accordance with the type of expense incurred and the places where service is provided.
Home Health Care	
Home Health Care Unlimited visits per Calendar Year	100% no copay per visit
Add Private Duty Nursing	100% no copay per visit
Hospice Care	
Hospice Care Unlimited visits per Calendar Year	100% no copay per visit
Medical Injectable Medications	
Medical Injectable Medications	$20 PCP or $30 specialist copay for adults and $20 for children to the end of year they turn 26
*Self-Injectable Medications are not covered under the medical plan. Please reach out to your pharmacy carrier for more details on self-injectable medications.	

Plan Features	In-Network Benefit
Durable Medical Equipment (DME)	
Durable Medical Equipment (DME)	100% (of the cost) after $100 deductible
Diabetic Supplies*	Payable in accordance with the type of expense incurred and the place where service is provided.
Important Note: There are specific diabetic supplies that are covered under the medical plan such as blood glucose monitors and monitor supplies (does not include blood glucose test strips), pump & pump supplies, diabetic shoes and orthotic devices. Disposable supplies are covered under your prescription drug plan. Please refer to your Prescription Drug guidebook for more information on diabetic disposable supplies.	
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	100% (of the cost) after $100 deductible or $20 copay for specific services noted in the State of New Jersey mandate. Some prostheses must be approved in advance by Aetna
Important Note: The provider's reimbursement for prosthetic and orthotic devices shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.	
Parenteral/Enteral Nutrition and Related Services	100% no copay
Wigs	100% (of the cost) after $100 deductible up to $500 Maximum every 24 months. Only covered if they are furnished in connection with hair loss resulting from treatment of disease by radiation or chemicals; alopecia universal is (totalis); alopecia areata, services are always covered regardless of whether a facility is participating or not.
Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per service
Outpatient Morbid Obesity Surgery	100% per service

Plan Features	In-Network Benefit
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	100% no copay per admission
Skilled Nursing Facilities Maximum of 120 days per Calendar Year	100% no copay per admission
Hospice Facility	100% no copay per admission
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery	
Performed at a Hospital Outpatient Facility	100% no copay per visit
Performed at a facility other than a Hospital Outpatient Facility	100% no copay per visit
Autism Spectrum Disorder	
Autism Physical Therapy, Occupational Therapy and Speech Therapy	$30 copay for adults and $20 copay for children up to the end of the year they turn 26 per visit
Autism - Behavioral Therapy	$30 copay for adults and $20 copay for children up to the end of the year they turn 26 per visit
Autism - Applied Behavior Analysis	$30 copay for adults and $20 copay for children up to the end of the year they turn 26 per visit
Mental Disorders	
During a Hospital Confinement	100% no copay per admission
During a Residential Treatment Facility Confinement	100% no copay per admission
Outpatient Mental Disorders Visits	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit

Plan Features	In-Network Benefit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies
Substance Abuse	
Detoxification and Rehabilitation	
During a Hospital confinement	100% no copay per admission
During a Residential Treatment Facility confinement	100% no copay per admission
Outpatient Substance Abuse Visits	
Detoxification	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit

Plan Features	In-Network Benefit
Rehabilitation Including Partial Hospitalization and Intensive Outpatient Programs	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies

Plan Features	In-Network Benefit
Maternity	
Mother	100% per admission
Newborn*	100% per admission
*Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered	
Emergency Care	
Hospital Emergency Room or Outpatient Department	$125 copay per visit
Urgent Care Facility	$30 copay for adults and $20 copay for children up to the end of year they turn 26 per visit
Ambulance	100% no copay per trip

Schedule of Benefits – Aetna HMO $20/$35 Plan

All non-emergency specialty and hospital services require a prior referral from your PCP, unless noted below as a "direct access" benefit.

Plan Features	In-Network Benefit
Plan Deductible	
Individual	$200
Family	$500
Annual Out of Pocket Limit Includes Deductible and includes copays $6,320 total individual out of pocket maximum per calendar year $12,640 total family out of pocket maximum per calendar year	
Individual	$2,000 per Calendar Year
Family	$5,000 per Calendar Year
Primary and Preventive Care	
PCP Office Visits Other than Preventive Care	$20 copay per visit
After Hours/Home Visits/Emergency Visits	$25 copay per visit
Routine Physical Examinations	The Plan pays 100% per visit No deductible applies.
Covered Persons through age 21: Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician log onto the Aetna website **Aetna.com** or call the number on the back of your ID card.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit

Plan Features	In-Network Benefit
Preventive Care Immunizations Performed in a facility or physician's office	The Plan pays 100% per visit No deductible applies.
Well Woman Preventive Visits Office Visits	The Plan pays 100% per visit No copay or deductible applies.
Maximum Visits per Calendar Year	1 visit
Routine Cancer Screenings	
Outpatient	No Calendar Year deductible applies.
Lung Cancer Screening Maximum 1 screening every calendar year Covered from age 55 years & older	Covered at 100% per visit No copay applies
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician, log onto the Aetna website **Aetna.com**, or call the number on the back of your ID card.
Screening & Counseling Services	
Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	The Plan pays 100% per visit No copay or deductible applies.
Obesity Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	

Plan Features	In-Network Benefit
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*
***Note:** In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.	
Family Planning Services	
Female Contraceptive Counseling Services - Office Visits.	100% no copay per visit
Family Planning Services - Female Voluntary Sterilization	
Inpatient	100% no copay per visit
Outpatient	100% no copay per visit
Breast Pumps & Supplies	Covered at 100% per item No copay applies
Family Planning Services – Female Contraceptives	
Female contraceptives that are generic prescription drugs • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per prescription or refill No deductible applies
Female contraceptive devices	100% per prescription or refill No deductible applies

Plan Features	In-Network Benefit
Preventive Care Drugs and Supplements	
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill No deductible applies
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
FDA-Approved Female Generic Emergency Contraceptives (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	The Plan pays 100% per prescription or refill No Calendar Year deductible applies.
Vision and Hearing Care	
Routine Eye Examinations direct access (no referral) to participating providers for periodic routine exams	$35 copay 1 visit per calendar year
Hearing Exam by an Audiologist (Children through age 15)	$35 copay 1 visit per calendar year
Hearing Aids (Children through age 15) Hearing supply maximum of $1,000 per ear per 24 months"	100% no copay per item No Calendar Year deductible applies.

Plan Features	In-Network Benefit
Nutritional Support	
Covers special formulas and low protein food products prescribed by a physician and certified medically necessary for certain conditions, not subject to any calendar year or lifetime maximum. 100% No deductible no copay for infant formula	Covered at 100% No copay
Specialty and Outpatient Care	
Specialist Office Visits	$35 copay per visit
Prenatal Care - for the first OB visit	100% no deductible after a $35 copay
Walk-In Clinic Visits	$20 copay per visit
Infertility Services	Copay based on where service is provided
Advanced Reproductive Technology Limited to 4 egg retrievals per lifetime	$35 copay per visit
Allergy Testing and Treatment Routine injections at PCP's or Specialist offiice	$20 PCP or $35 Specialist copay per visit with physician encounter 100% no copay when there is no physician encounter
Outpatient Facility Visits When rendered in home office or outpatient facility	
Chemotherapy	100% no copay per visit
Radiation Therapy	100% no copay per visit
Infusion Therapy* *No copay when done in conjunction with Chemotherapy and a cancer diagnosis	$35 copay per visit
Cardiac Rehabilitation	$35 copay per visit

Plan Features	In-Network Benefit
X-rays and Lab Tests	
Performed at a Hospital Outpatient Facility	80% after deductible per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) Precertification required	80% after deductible per visit
Performed at a facility other than a Hospital Outpatient Facility	80% after deductible per visit
Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT);and Positron Emission Tomography (PET) Precertification required	80% after deductible per visit
Outpatient Therapy	
Outpatient Therapy (speech, occupational, physical)	$35 copay per visit Subject to medical necessity review
Spinal Manipulation	$35 copay per visit Limited to 20 visits per calendar year and subject to medical necessity
Acupuncture benefit Only covered in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.
Habilitation Therapy Services	
Outpatient physical, occupational, and speech therapy	$35 copay per visit

Plan Features	In-Network Benefit
Clinical Trial Therapies	
Clinical Trial Therapies (Experimental or Investigational Treatment for Clinical Trials Only)	Payable in accordance with the type of expense incurred and the places where service is provided.
Clinical Trial Therapies (Routine Patient Costs)	Payable in accordance with the type of expense incurred and the places where service is provided.
Home Health Care	
Home Health Care Unlimited visits per Calendar Year	80% after deductible per visit
Private Duty Nursing	80% after deductible per visit
Hospice Care	
Hospice Care Unlimited visits per Calendar Year	80% after deductible per visit
Medical Injectable Medications	
Medical Injectable Medications	$20 PCP or $35 Specialist copay per visit per prescription*
*Self-Injectable Medications are not covered under the medical plan. Please reach out to your pharmacy carrier for more details on self-injectable medications.	
Durable Medical Equipment (DME)	
Durable Medical Equipment (DME)	80% after deductible per item
Diabetic Supplies*	Payable in accordance with the type of expense incurred and the place where service is provided.
Important Note: There are specific diabetic supplies that are covered under the medical plan such as blood glucose monitors and monitor supplies (does not include blood glucose test strips), pump & pump supplies, diabetic shoes and orthotic devices. Disposable supplies are covered under your prescription drug plan. Please refer to your Prescription Drug guidebook for more information on diabetic disposable supplies.	

Plan Features	In-Network Benefit
Prosthetic and Orthotic Devices	
Prosthetic and Orthotic Devices	80% (of the cost) after deductible or $20 copay for specific services noted in the State of New Jersey mandate. Some prostheses must be approved in advance by Aetna
Important Note: The provider's reimbursement for prosthetic and orthotic devices shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.	
Parenteral/Enteral Nutrition and Related Services	100% no copay
Wigs	80% (of the cost) after deductible up to $500 Maximum every 24 months. Only covered if they are furnished in connection with hair loss resulting from treatment of disease by radiation or chemicals; alopecia universal is (totalis); alopecia areata, services are always covered regardless of whether a facility is participating or not.
Morbid Obesity Surgical Treatment Benefits	
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services).	80% after deductible per service
Outpatient Morbid Obesity Surgery	80% after deductible per service
Inpatient Services	
Hospital Room and Board and Other Inpatient Services	80% after deductible per admission
Skilled Nursing Facilities Maximum of 120 days per Calendar Year	80% after deductible per admission
Hospice Facility	80% after deductible per admission

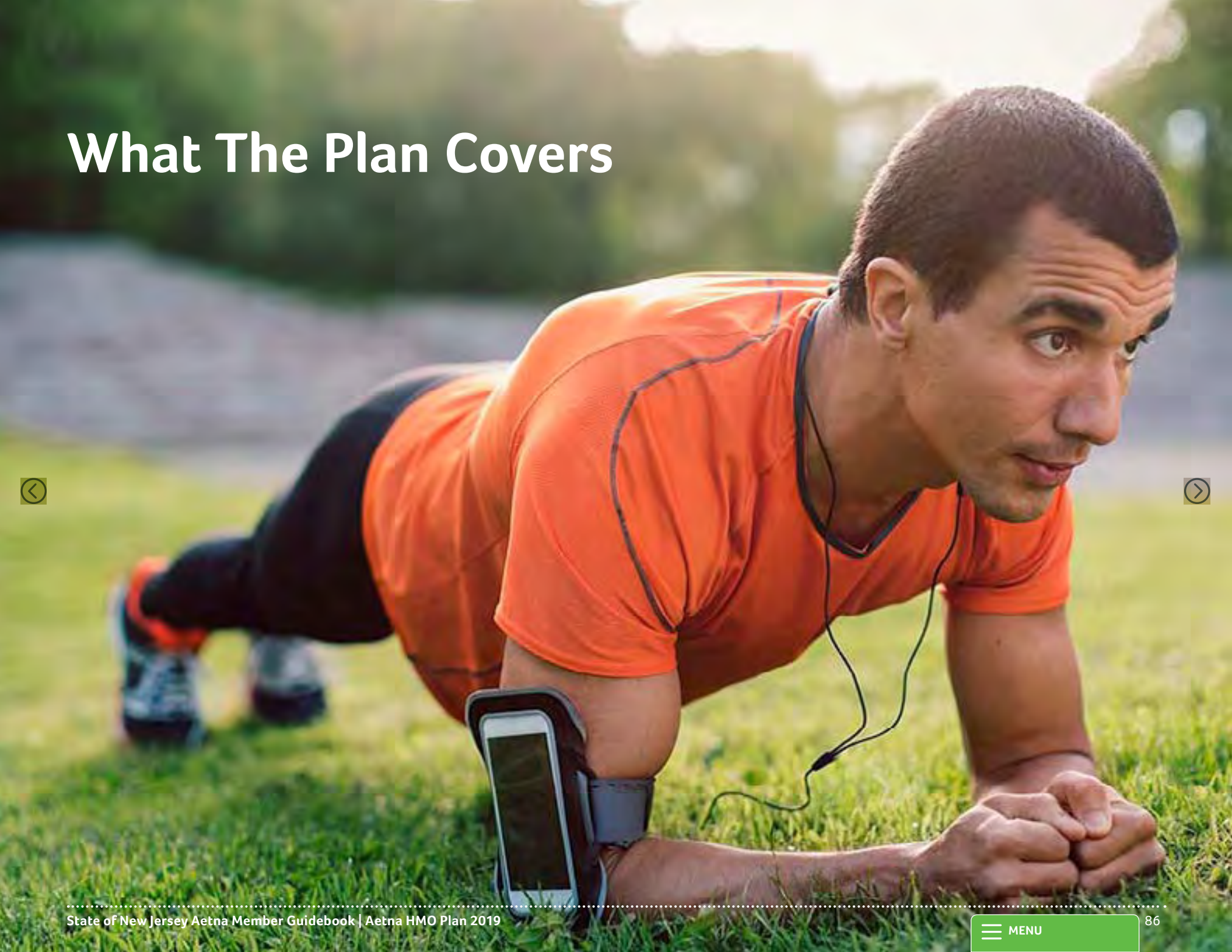
Plan Features	In-Network Benefit
Surgery and Anesthesia	
Inpatient Surgery	Subject to inpatient copay shown above
Outpatient Surgery	
Performed at a Hospital Outpatient Facility	80% after deductible per visit
Performed at a facility other than a Hospital Outpatient Facility	80% after deductible per visit
Autism Spectrum Disorder	
Autism Physical Therapy, Occupational Therapy and Speech Therapy	$35 copay per visit
Autism - Behavioral Therapy	$35 copay per visit
Autism - Applied Behavior Analysis	$35 copay per visit
Mental Disorders	
During a Hospital Confinement	100% no copay per admission
During a Residential Treatment Facility Confinement	80% after deductible per admission
Outpatient Mental Disorders Visits	$35 copay per visit.
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$35 copay per visit

Plan Features	In-Network Benefit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies
Substance Abuse	
Detoxification and Rehabilitation	
During a Hospital confinement	100% no copay per admission
During a Residential Treatment Facility confinement	80% after deductible per admission
Outpatient Substance Abuse Visits	
Detoxification	$35 copay per visit
Rehabilitation Including Partial Hospitalization and Intensive Outpatient Programs	$35 copay per visit

Plan Features	In-Network Benefit
Outpatient Office visits to a physician or behavioral health provider (includes telemedicine and/or telehealth consultation) cognitive behavior therapy consultations	$35 copay per visit
Other outpatient mental health treatment (includes skilled behavioral health services in the home): - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician (at least 4 hours, but less than 24 hours per day of clinical treatment) - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician (at least 2 hours per day and at least 6 hours per week of clinical treatment)	0% (of the negotiated charge) per visit No Deductible applies

Plan Features	In-Network Benefit
Maternity	
Mother	100% per admission
Newborn*	100% per admission
*Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered	
Emergency Care	
Hospital Emergency Room or Outpatient Department	$300 copay per visit
Urgent Care Facility	$35 copay per visit
Ambulance	80% after deductible per trip

What The Plan Covers



What The Plan Covers

Aetna HMO Medical Plan

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

Preventive Care

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

Important Note

1. The recommendations and guidelines of the:

a. Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

a. United States Preventive Services Task Force;

a. Health Resources and Services Administration; and

a. American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

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

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

Click on healthcare.gov for more information on preventive care:
https://www.healthcare.gov/coverage/preventive-care-benefits/

Your Benefits

Your Benefits

Although a specific service may be listed as a covered benefit, it may not be covered unless it is medically necessary for the prevention, diagnosis or treatment of your illness or condition. Refer to the "Glossary" section for the definition of "medically necessary."

Certain services must be precertified by Aetna. Your participating provider is responsible for obtaining this approval.

Primary and Preventive Care

One of the Plan's goals is to help you maintain good health through preventive care. Routine exams, immunizations and well-child care contribute to good health and are covered by the Plan (after any applicable copayment) if provided by your PCP or on referral from your PCP:

- Office visits with your PCP during office hours and during non-office hours.
- Home visits by your PCP.
- Treatment for illness and injury.
- Health education counseling and information.
- Periodic eye examinations. You may visit a participating provider without a referral for one exam every 24 months.
- Routine hearing screenings performed by your PCP as part of a routine physical examination for children under the age of 16.

Routine Physical Exams

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

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

Limitations:

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

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

Preventive Care Immunizations

Covered expenses include charges made by your physician or a facility for:

- immunizations for infectious diseases; and
- the materials for administration of immunizations;

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

Limitations

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

Well Woman Preventive Visits

- Breast Tomosynthesis (3D Mammograms). There is no member cost sharing for preventive 3-D mammogram screening for members ages 40 years and older.

Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Limitations:

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

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

Routine Cancer Screenings

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

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

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

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

Limitations:

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

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

Important Notes:

Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Preventive Care.

For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your physician, log onto the Aetna website Aetna.com, or call the member services at the number on the back of your ID card.

Screening and Counseling Services

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

Obesity

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

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

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Misuse of Alcohol and/or Drugs

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

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of Tobacco Products

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

- preventive counseling visits;
- treatment visits; and
- class visits;

to aid in the cessation of the use of tobacco products.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations:

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.

Family Planning Services - Female Contraceptives

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

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

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

Contraceptives

Covered expenses include charges made by a physician or pharmacy for:

- Female contraceptive devices including the related services and supplies needed to administer the device;
- FDA-approved female: generic emergency contraceptives,
- Over-the-counter and generic prescription drugs and devises for each of the methods identified by the FDA at no cost share. If a generic prescription drug or device is not available for certain method, you may obtain certain brand-name prescription drug for that method at no cost share.

When contraceptive methods are obtained at a pharmacy, prescriptions must be submitted to the pharmacist for processing. If you have prescription drug coverage, use your prescription drug coverage to obtain contraceptive medications. If you wish to use your medical coverage and need to be reimbursed for purchased contraceptive medications, please contact member services on the back of your ID card.

Limitations:

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

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

Specialty and Outpatient Care

The Plan covers the following specialty and outpatient services. You must have a prior written or electronic referral from your PCP in order to receive coverage for any non-emergency services the specialist or facility provides.

- Participating specialist office visits.

- Participating specialist consultations, including second opinions.
- Outpatient surgery for a covered surgical procedure when furnished by a participating outpatient surgery center. All outpatient surgery must be approved in advance by Aetna.
- Preoperative and postoperative care.
- Casts and dressings.
- Compression Stockings.
- Radiation therapy.
- Cancer chemotherapy.
- Breast Tomosynthesis (3D Mammograms). There is no member cost sharing for preventive 3-D mammogram screening for members ages 40 years and older.
- Short-term speech, occupational (except vocational rehabilitation and employment counseling), and physical therapy for treatment of non-chronic conditions and acute illness or injury.
- Cognitive therapy associated with physical rehabilitation for treatment of non-chronic conditions and acute illness or injury.
- Short-term cardiac rehabilitation provided on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Short-term pulmonary rehabilitation provided on an outpatient basis for the treatment of reversible pulmonary disease.
- Diagnostic, laboratory and X-ray services.
- Emergency care including ambulance service - 24 hours a day, 7 days a week (see "In Case of Emergency").
  - Ambulance use for local emergency transport to the nearest facility equipped to treat the emergency condition is covered subject to medical necessity at the appropriate level of care. If emergency air transport is needed it must be medically necessary and approved by having your physician contact Aetna.
- Home health services provided by a participating home health care agency, including:
  - skilled nursing services provided or supervised by an RN.
  - services of a home health aide for skilled care.
  - medical social services provided or supervised by a qualified physician or social worker if your PCP certifies that the medical social services are necessary for the treatment of your medical condition.

Home health care services do not include custodial care or applied behavior analysis.

- Outpatient hospice services for a Plan participant who is terminally ill, including:
  - counseling and emotional support.
  - home visits by nurses and social workers.
  - pain management and symptom control.
  - instruction and supervision of a family member.
  - respite care. This is care provided when the patient's family or usual caretaker cannot care for the patient.

NOTE: The Plan does not cover the following hospice services:

  - bereavement counseling, funeral arrangements, pastoral counseling, or financial or legal counseling.
  - homemaker or caretaker services and any service not solely related to the care of the terminally ill patient.
  - treatment not included in the Aetna Compassionate Care Program.
- Oral surgery (limited to extraction of bony, impacted teeth, treatment of bone

fractures, removal of tumors and orthodontogenic cysts).

- Reconstructive breast surgery following a mastectomy, including:
  - reconstruction of the breast on which the mastectomy is performed, including areolar reconstruction and the insertion of a breast implant;
  - surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed; and
  - treatment of physical complications of all stages of mastectomy, including lymphedemas.

Infertility services to diagnose and treat infertility

Infertility is a condition that results in the abnormal function of the reproductive system, as determined pursuant to American Society for Reproductive Medicine practice guidelines by a physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology; or the patient has met one of the following conditions:

- a male is unable to impregnate a female;
- a female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse;
- a female with a male partner and 35 years of age and over is unable to conceive after six months of unprotected sexual intercourse;
- a female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision;
- a female without a male partner and over 35 years of age who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision;
- partners are unable to conceive as a result of involuntary medical sterility;
- a person is unable to carry a pregnancy to live birth; or
- a previous determination of infertility pursuant to the State of New Jersey Infertility Mandate.

Basic Infertility Expenses

Covered expenses include charges made by a 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 an 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 an infertility specialist upon pre-authorization by Aetna, subject to all the exclusions and limitations of this Booklet:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the Schedule of Benefits section of this Booklet and has a maximum of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by Aetna or any affiliated company of Aetna); and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in the Schedule of Benefits section of this Booklet and has a maximum of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by Aetna or any affiliated company of Aetna).

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 an ART specialist.

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) 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.

Infertility Exclusions

The Plan does not cover the following infertility services:

- Reversal of male and female voluntary sterilization.
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal.

- Non-medical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, are covered until the donor is released from treatment by the reproductive endocrinologist.
- Purchase of donor sperm.
- Storage of sperm.
- Purchase of donor eggs.
- Cryopreservation or storage of cryopreserved eggs or embryos.
- Any experimental, investigational or unproven infertility procedures or therapies.
- All charges associated with gestational carrier programs, for either the covered person or the gestational carrier.
- Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract.
- Ovulation kits and sperm testing kits and supplies.
- In vitro fertilization, gamete intrafallopian tube transfer and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or are 46 years of age or older.
- The number of covered embryo transfers are limited by the number of eggs retrieved in the lifetime maximum of 4 completed egg retrievals, or are 46 years of age and older.
- Infertility services that are not reasonably likely to be successful.
- Services received by a spouse or partner who is not covered by the Plan.
- Services and supplies obtained without the necessary claim authorization from Aetna's Infertility Case Management Unit

Durable Medical Equipment

- Prosthetic appliances and orthopedic braces (including repair and replacement when due to normal growth). Certain prosthetics require preauthorization by Aetna.
- Durable medical equipment (DME), prescribed by a physician for the treatment of an illness or injury.

The Plan covers instruction and appropriate services required for the Plan participant to properly use the item, such as attachment or insertion, if approved by Aetna. Replacement, repair and maintenance are covered only if:

- they are needed due to a change in your physical condition, or
- it is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

The request for any type of DME must be made by your physician and coordinated through Aetna.

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.

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 existenceof comorbid conditions; except as provided in this booklet.

Transgender Reassignment (Sex Change) Surgery

Eligibility for this benefit is limited to you and your qualified dependent age 18 or older, having met Aetna's criteria for diagnosis of "true" transsexualism, and documented completion of a recognized program at a specialized gender identity treatment center. Aetna's policies regarding the eligibility for Gender Reassignment Surgery (as described in Aetna's Clinical Policy Bulletin 0615) and other procedures and services are available in the Medical Clinical Policy Bulletins, accessible on Aetna Navigator.

You and your qualified dependent must meet criteria for the diagnosis of "true" transsexualism, including:

- Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; and
- A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; and
- Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; and
- Does not gain sexual arousal from cross-dressing; and
- Absence of physical inter-sex of genetic abnormality; and
- Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia.

Covered Expenses

Covered expenses include charges in connection with a medically necessary Transgender Reassignment (sometimes called Sex Change) Surgery as long you or a covered dependent have obtained precertification from Aetna.

Covered expenses include: Charges made by a physician for:

- Charges for psychotherapy for gender identity disorders;
- Performing the surgical procedure;
- Pre- and post-operative hospital and office visits; and
- Pre- and post-operative hormone replacement treatment.

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. Daily room and board charges over the 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.
- Genital reconstruction surgery including, but not limited to, hysterectomy, oophorectomy and mastectomy. The Aetna Clinical Policy Bulletin 0615 will provide a comprehensive list of covered surgeries.

Limitations:

- The plan does not cover expenses in excess of one surgical procedure per covered person per lifetime.

Inpatient Care in a Hospital, Skilled Nursing Facility or Hospice

If you are hospitalized by a participating PCP or specialist (with prior referral except in emergencies), you receive the benefits listed below. See "Behavioral Health" for inpatient mental health and substance abuse benefits.

- Confinement in semi-private accommodations (or private room when medically necessary and certified by your PCP) while confined to an acute care facility.
- Confinement in semi-private accommodations in an extended care/ skilled nursing facility.
- Confinement in semi-private accommodations in a hospice care facility for a Plan participant who is diagnosed as terminally ill.
- Intensive or special care facilities.
- Visits by your PCP while you are confined.
- General nursing care.
- Surgical, medical and obstetrical services provided by the participating hospital.
- Use of operating rooms and related facilities.
- Medical and surgical dressings, supplies, casts and splints.
- Drugs and medications.
- Intravenous injections and solutions.
- Administration and processing of blood, processing fees and fees related to autologous blood donations. Covers blood, blood plasma, including but not limited derivatives and synthetic blood products. (Blood by donation from a blood bank is not covered.)
- Nuclear medicine.
- Preoperative care and postoperative care.
- Anesthesia and anesthesia services.
- Oxygen and oxygen therapy.
- Inpatient physical and rehabilitation therapy, including:
  - cardiac rehabilitation; and
  - pulmonary rehabilitation.
- X-rays (other than dental X-rays), laboratory testing and diagnostic services.
- Magnetic resonance imaging.
- Transplant services are covered if the transplant is not experimental or investigational and has been approved in advance by Aetna. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluation and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. A transplant will be covered only

if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered as an out-of-network facility for transplant-related services, even if the facility is considered as a participating facility for other types of services.

Maternity

The Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. In accordance with the Newborn and Mothers Healthcare Protection Act, you and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). However, your provider may – after consulting with you – discharge you earlier than 48 hours after a vaginal delivery (96 hours following a cesarean section).

You do not need a referral from your PCP for visits to your participating obstetrician. A list of participating obstetricians can be found in your provider directory or on DocFind (see "Provider Information").

Note

Your participating obstetrician is responsible for obtaining precertification from Aetna for all obstetrical care after your first visit. They must request approval (precertification) for any tests performed outside of their office and for visits to other specialists. Please verify that the necessary referral has been obtained before receiving such services.

If you are pregnant at the time you join the Plan, you receive coverage for authorized care from participating providers on and after your effective date. There is no waiting period. Coverage for services incurred prior to your effective date with the Plan are your responsibility or that of your previous plan.

Behavioral Health

Your mental health/substance abuse benefits will be provided by participating behavioral health providers. You do not need a referral from your PCP to obtain care from participating mental health and substance abuse providers. Instead, when you need mental health or substance abuse treatment, call the behavioral health telephone number at 1-866-230-9951. This is on the back of your ID card. Behavioral health and substance use disorder care is available 24 hours a day, seven days a week. All calls are confidential. A clinical care manager will assess your situation and refer you to participating providers, as needed.

Mental Disorders Benefits

You are covered for treatment of a mental disorder through participating behavioral health providers as follows:

- Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximums, if any, shown on the Schedule of Benefits.
- Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, hospital or non-hospital residential treatment facility, appropriately licensed by the Department of Health or its equivalent. Coverage, if applicable, is subject to the maximums, if any, shown on the Schedule of Benefits.

Mental health treatment

- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultation)
  - Other outpatient mental health treatment such as:
  - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician
  - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your physician orders them
  - The services take the place of a stay in a hospital or a residential treatment facility, or needing to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- oPsychological testing
- Neuropsychological testing
- 23 hour observation
- Peer counseling support by a peer support specialist
- A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Substance Abuse Benefits

You are covered for the following services as authorized and provided by participating behavioral health providers:

- Outpatient care benefits are covered for detoxification. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by your PCP for the abuse of or addiction to alcohol or drugs.
- You are entitled to outpatient visits to a participating behavioral health provider upon referral by your PCP for diagnostic, medical or therapeutic substance abuse rehabilitation services. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.
- Inpatient care benefits are covered for detoxification. Benefits include medical treatment and referral services for substance abuse or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; physicians, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies.
- You are entitled to medical, nursing, counseling or therapeutic substance abuse rehabilitation services in an inpatient, hospital or non-hospital residential treatment facility, appropriately licensed by the Department of Health, upon referral by your participating behavioral health provider for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

Substance Abuse Outpatient

Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:

- Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine and/or telehealth consultation)
- Individual, group and family therapies for the treatment of substance use disorders
- Other outpatient substance use disorders treatment such as:
  - Outpatient detoxification
  - Partial hospitalization treatment provided in a facility or program for treatment of substance use disorders provided under the direction of a physician. These days will count as inpatient treatment.
  - Intensive outpatient program provided in a facility or program for treatment of substance use disorders provided under the direction of a physician. These days will count as inpatient treatment.
  - Ambulatory detoxification which are outpatient services that monitor withdrawal from alcohol or other substance use, including administration of medications
  - Treatment of withdrawal symptoms
  - 23 hour observation
  - Peer counseling support by a peer support specialist
    - A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Habilitation therapy services

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

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

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

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

Outpatient physical, occupational, and speech therapy

Eligible health services include:

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

- Speech function is the ability to express thoughts, speak words and form sentences.

Autism or Another Developmental Disability

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

Effective February, 8, 2010, Chapter 115, P.L. 2009, requires that the SHBP/SEHBP provide:

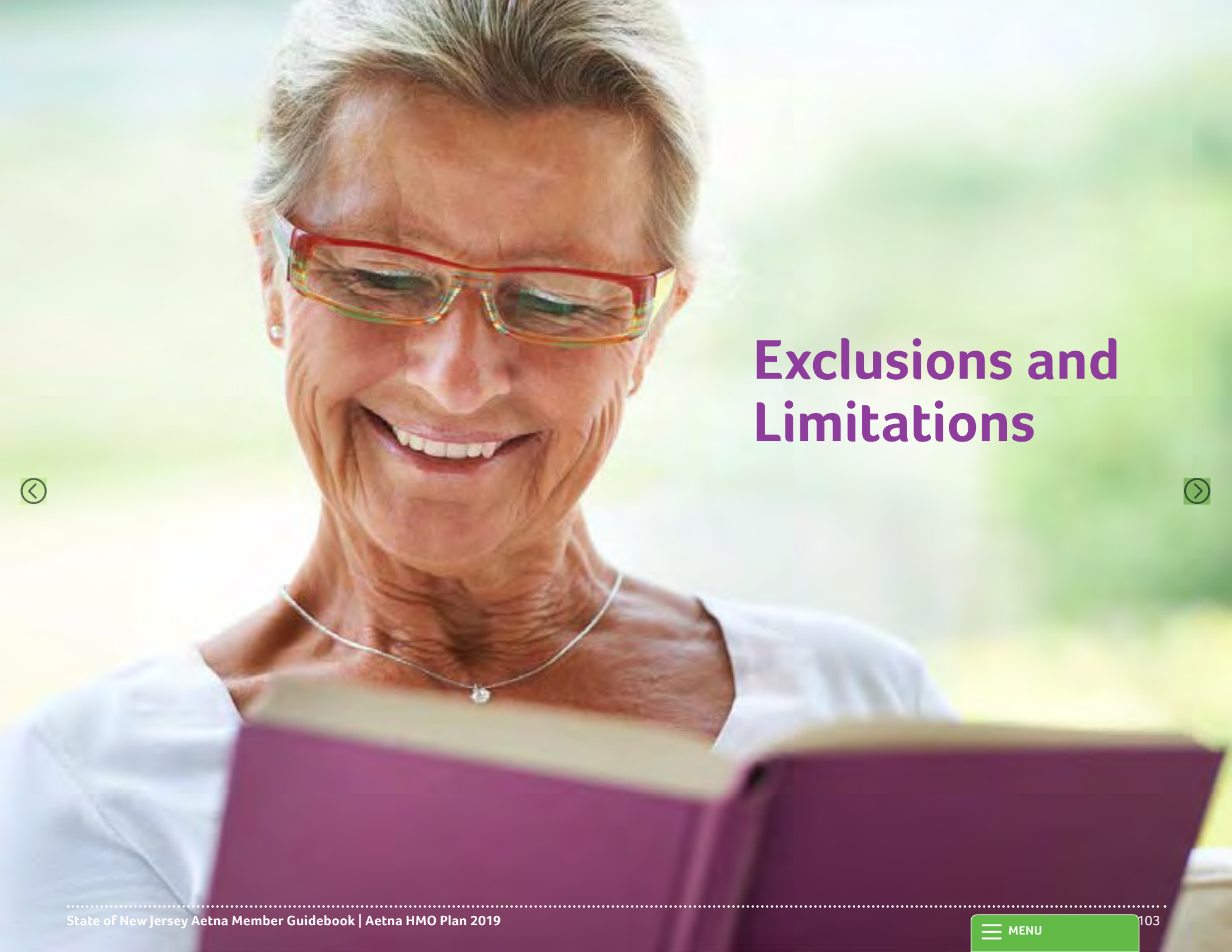
- Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
- Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
- Coverage for expenses incurred for medically necessary behavioral interventions (ABA therapy) for individuals under 21 years of age diagnoses with autism;
- A benefit for the Family Cost Share portion of expenses incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).
- There is no dollar benefit maximum for ABA therapy services per year for children with autism. ABA therapy is not eligible for children with developmental diagnoses.
- Aetna Behavioral Health must be contacted to precertify ABA services for autistic children.
- Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of autism spectrum disorder or pervasive developmental disability. We will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.

Prescription Drugs

The Plan covers only prescription drugs administered while you are an inpatient in a covered health care facility. Please refer to the separate booklet describing the outpatient prescription drug coverage available through a separate vendor.

Note

You may qualify for a medical exception if your provider determines that the contraceptives covered standardly as preventive are not medically appropriate. Your prescriber may request a medical exception and submit the exception to us.



Exclusions and Limitations

Exclusions

The Plan does not cover the following services and supplies:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan.
- Any services or supplies that are not medically necessary, as determined by Aetna.
- Biofeedback, except as specifically approved by The Plan.
- Breast augmentation and otoplasties, including treatment of gynecomastia.
- Canceled office visits or missed appointments.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. However, the Plan covers the following:
  - reconstructive surgery to correct the results of an injury.
  - surgery to treat congenital defects (such as cleft lip and cleft palate) to restore normal bodily function.
  - surgery to reconstruct a breast after a mastectomy that was done to treat a disease, or as a continuation of a staged reconstructive procedure.
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically necessary and provided by participating providers upon referral from your PCP.
- Custodial care and rest cures.
- Dental care and treatment, except as specified under "Your Benefits". The Plan does not cover:
  - care, filling, removal or replacement of teeth;
  - dental services related to the gums;
  - apicoectomy (dental root resection);
  - orthodontics;
  - root canal treatment;
  - soft tissue impactions;
  - alveolectomy;
  - augmentation and vestibuloplasty treatment of periodontal disease;
  - prosthetic restoration of dental implants; and
  - dental implants.
- Drugs and medicines which by law need a physicians prescription and for which no coverage is provided under the Prescription Drug Expense Coverage.
- Educational services, special education, remedial education or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan.

- Expenses that are the legal responsibility of Medicare or a third party payor.
- Experimental and investigational services and procedures except in the case of an approved clinical trial; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by Aetna, unless approved by Aetna in advance.

This exclusion will not apply to drugs:

- that have been granted treatment investigational new drug (IND) or Group c/ treatment IND status;
- that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
- that Aetna has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease.

Refer to the "Glossary" for a definition of "experimental or investigational."

- False teeth.
- Hair analysis.
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated.
- Eyeglasses, or contact lenses or the fitting thereof, except as specified under "Your Benefits."
- Lenses of any type except initial lens replacement for loss of the natural lens after cataract surgery.
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, is not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides and swimming pools, are not covered.
- Hypnotherapy, except when approved in advance by Aetna.
- Immunizations related to travel or work.
- Implantable drugs .
- Infertility services and supplies as follows:
  - Charges associated with cryopreservation, storage of cryopreserved sperm, eggs or embryos;
  - Infertility treatments that are experimental or investigational in nature;
  - Home ovulation predictor kits, sperm testing kits and supplies;
  - Prescription drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary;
  - Non-medical costs of an egg or sperm donor; except as listed in What The Plan Covers section for the Treatment of Infertility;
  - Reversal of prior voluntary sterilization procedures, except coverage for infertility services provided to partners of person who have successfully reversed sterilization may not be excluded provided that the partner is infertile as defined by P. L. 2001, c. 236 and New Jersey Administrative Code 11:4-54.1-54.7;
  - Infertility that results from voluntary sterilization (even if the person has attempted to reverse sterilization) or payment for medical services rendered to a surrogate for purposes of childbearing;
  - Any charges associated with obtaining sperm for non-covered persons;
  - Services rendered to a surrogate for the purposes of childbearing, if the surrogate is not a covered person; and

- Infertility prescription drugs to the extent covered elsewhere under this Booklet-Certificate or under another Group Plan sponsored by the Policyholder.

- Oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions and preventive care.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Orthotics, except as specified under your benefits.
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips.
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services.
- Radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Recreational, educational and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including related services and treatment.
- Reversal of voluntary sterilizations, including related follow-up care.
- Routine hand and foot care services, including routine reduction of nails, calluses and corns.
- Services not covered by the Plan, even when your PCP has issued a referral for those services.
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation.
- Services provided by your close relative (your spouse, child, brother, sister, or the parent of you or your spouse) for which, in the absence of coverage, no charge would be made.
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
  - obtaining or continuing employment;
  - obtaining or maintaining any license issued by a municipality, state or federal government;
  - securing insurance coverage;
  - travel; and
  - school admissions or attendance, including examinations required to participate in athletics, unless the service is considered to be part of an appropriate schedule of wellness services.
- Services and supplies that are not medically necessary.
- Services you are not legally obligated to pay for in the absence of this coverage.
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability.
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation.
- Specific injectable drugs, including:
  - experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the FDA and the National Institutes of Health, injectable drugs not considered medically necessary or used for cosmetic, performance, or

enhancement purposes, or not specifically covered under this plan;

- drugs related to treatments not covered by the Plan; and
- drugs related to the treatment of infertility, contraception, and performance-enhancing.
- Specific non-standard allergy services and supplies, including (but not limited to):
- skin titration (rinkel method);
- cytotoxicity testing (Bryan's Test);
- treatment of non-specific candida sensitivity; and
- urine autoinjections.

- Speech therapy for treatment of delays in speech development except when deemed medically necessary for a member with autism or PDD.
- Surgical operations, procedures or treatment of obesity, except when approved in advance by Aetna.
- Therapy or rehabilitation, including (but not limited to):
  - primal therapy;
  - chelation therapy;
  - rolfing;
  - psychodrama;
  - megavitamin therapy;
  - purging;
  - bioenergetic therapy;
  - vision perception training;
  - carbon dioxide therapy.
- Thermograms and thermography.
- Treatment in a federal, state or governmental facility, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment, including therapy, supplies and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Treatment of diseases, injuries or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you.
- Treatment of injuries sustained while committing a felony.
- Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under "Your Benefits."
- Treatment of occupational injuries and occupational diseases, including injuries that arise out of (or in the course of) any work for pay or profit, or in any way result from a disease or injury which does. If you are covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular disease or injury under such law, that disease or injury will be considered "non-occupational," regardless of cause.
- Treatment of 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 for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column.
- Treatment of temporomandibular joint (TMJ) syndrome, including (but not limited to):
  - treatment performed by placing a prosthesis directly on the teeth;
  - surgical and non-surgical medical and dental services; and
  - diagnostic or therapeutic services related to TMJ.

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

Financial Sanctions Exclusion

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

Limitations

In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, the Plan reserves the right to cover only the least costly service, as determined by Aetna, provided that Aetna approves coverage for the service or treatment in advance.

In Case of Medical Emergency

In Case of Medical Emergency

Guidelines

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. Aetna has adopted the following definition of an emergency medical condition from the Balanced Budget Act (BBA) of 1997:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies are:

- Heart attack or suspected heart attack;
- Suspected overdose of medication;
- Poisoning;
- Severe burns;
- Severe shortness of breath;
- High fever (especially in infants);
- Uncontrolled or severe bleeding;
- Loss of consciousness.

Whether you are in or out of Aetna's service area, we ask that you follow the guidelines below when you believe you may need emergency care.

1. Call your PCP first, if possible. Your PCP is required to provide urgent care and emergency coverage 24 hours a day, including weekends and holidays. However, if a delay would be detrimental to your health, seek the nearest emergency facility, or dial 911 or your local emergency response service.
2. After assessing and stabilizing your condition, the emergency facility should contact your PCP so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible. The emergency room copayment will be waived if you are admitted to the hospital.
4. All follow-up care must be coordinated by your PCP.
5. If you go to an emergency facility for treatment that Aetna determines is non-emergency in nature, you will be responsible for the bill. The Plan does not cover non-emergency use of the emergency room.

Follow-Up Care After Emergencies

All follow-up care should be coordinated by your PCP. You must have a referral from your PCP and approval from Aetna to receive follow-up care from a nonparticipating provider. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays, and clinic and emergency room revisits are some examples of follow-up care.

Urgent Care

Treatment that you obtain outside of your service area for an urgent medical condition is covered if:

- The service is a covered benefit;
- You could not reasonably have anticipated the need for the care prior to leaving the network service area; and
- A delay in receiving care until you could return and obtain care from a participating network provider would have caused serious deterioration in your health.

Urgent care from participating providers within your service area is covered if your PCP is not reasonably available to provide services to you. You should first seek care through your PCP. Referrals to participating urgent care providers are not required, but the care must be urgent, non-preventive or non-routine.

Some examples of urgent medical conditions are:

- Severe vomiting;
- Sore throat;
- Earaches;
- Fever.

Follow-up care provided by your PCP is covered, subject to the office visit copayment. Other follow-up care by participating specialists is fully covered with a prior written or electronic referral from your PCP, subject to the specialist copay shown in the "Schedule of Benefits."

What to Do Outside Your Aetna Service Area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, or an urgent care center. An urgent medical condition that occurs outside your Aetna service area can be treated in any of the above settings. You should call your PCP before receiving treatment from a non-participating urgent care provider.

If, after reviewing information submitted to Aetna by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. Aetna will send you an Emergency Room Notification Report or a customer service professional (CSP) can take this information over the telephone.

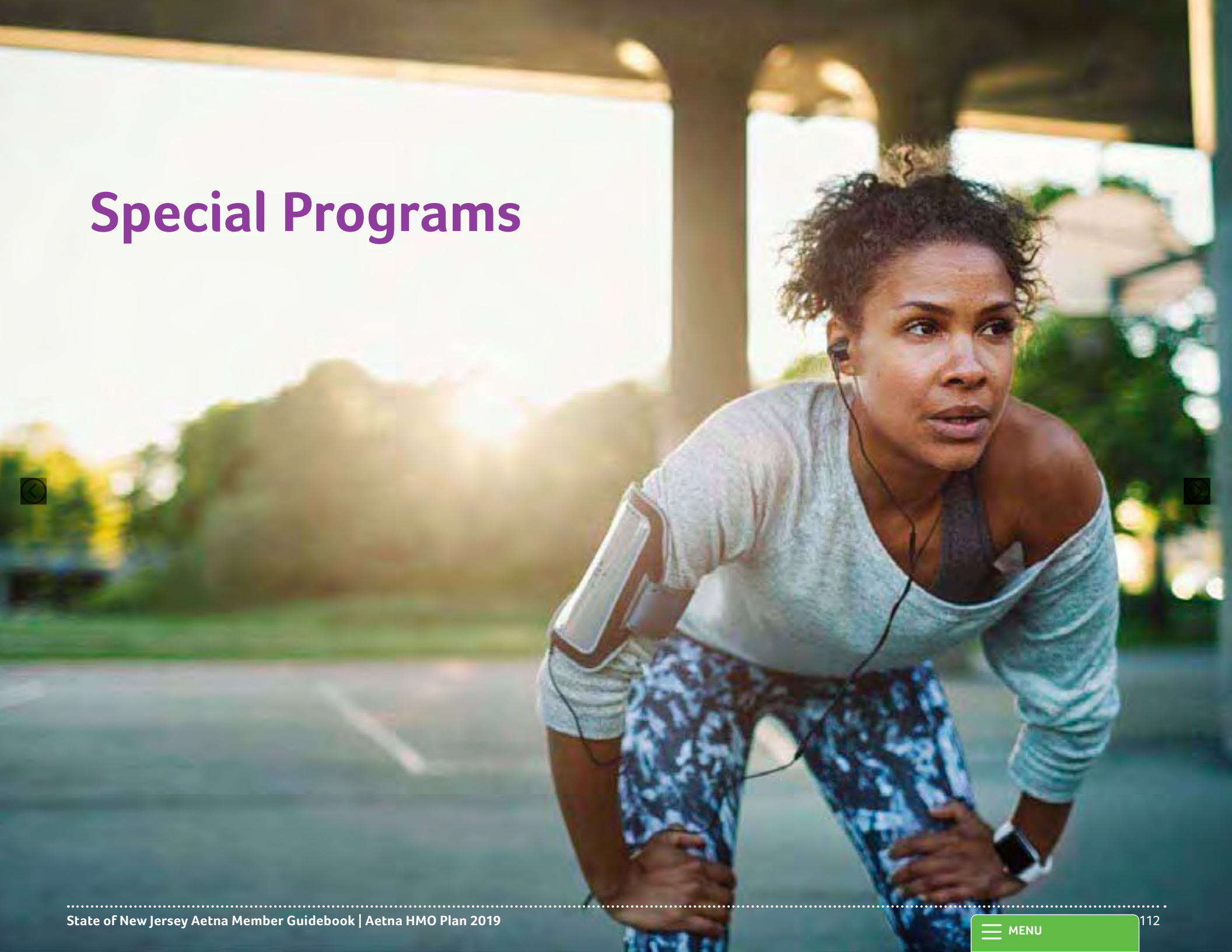
If Your Child Does Not Reside With You

If your child does not live with you, but they live in another Aetna service area, they can choose a PCP in that service area. Members who reside outside of New Jersey, Pennsylvania, New York, Maryland, Delaware and Florida will be placed in the Aetna Select network. Your child's coverage under the Plan will then be the same as yours.

A child covered by the Plan who does not reside in where the Aetna Network is available, can choose a PCP in your network and return to your network service area for care.

In the event of an emergency that occurs outside of your service area, out-of-area dependents should obtain necessary care as described under "In Case of Emergency," then contact their PCP to coordinate follow-up care.

Special Programs



Special Programs

Special Programs

Aetna Discount Program

Save on a variety of products and services with the Aetna Discount Program. The discounts can help you save money on what matters most to you - because it's your health, your wellness and your life.

You can access these discounts at no additional cost to you. You can use them whenever you want, as many times as you want. There are no claim forms or referrals. And, your family members may be able to save, too.

At Home Products

Save on arm and wrist blood pressure monitors and much more for you and your family from Omron Healthcare Inc.

Books

Save on books, DVDs and other items purchased from the American Cancer Society Bookstore, the Mayo Clinic Bookstore and for yoga-related titles, Pranamaya.

Fitness

You and your family members can save on gym memberships[1] and name-brand home fitness and nutrition products that support your healthy lifestyle with services provided by GlobalFit®. The GlobalFit network has thousands of gyms in the United States, including national chains and independent local facilities.

Hearing

You can take care of your hearing and save money on products and services from Hearing Care Solutions and Amplifon Hearing Health Care. Save on hearing exams and hearing aids, get free in-office services, and more.

LifeMart®

Get discounts on millions of products and services from thousands of merchants nationwide on the LifeMart shopping website. You can find discounts in categories such as travel, tickets, electronics, home, auto, grocery coupons, wellness, family care and much more.

Natural Products and Services[1]

Save on specialty health care services and natural products through the ChooseHealthy®[2] program. Get a discount off the normal fee for acupuncture, massage therapy, chiropractic and nutrition services. Also save on the retail price of health and wellness products on the ChooseHealthy website.

You can also save on online provider consultations through the Vital Health Network (VHN). You have access to the VHN network of doctors who provide online consultations and alternative remedies for a variety of conditions.

How to learn more about and get your discounts

From Aetna website, your secure member website, select "Discounts" to read about each vendor's offering and how you can take advantage of the discounts on these products and services. Then link over to the vendors' websites to purchase products and services from them.

1 Participation in GlobalFit is for new gym members only. If you belong to a gym now or belonged recently, call GlobalFit to see if a discount applies.

2 The ChooseHealthy program is made available through American Specialty Health Administrators, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Vision

You can take care of your vision and save with EyeMed. Get discounts on eye exams, eyeglass frames and lenses, non-disposable contact lenses and solutions, LASIK eye surgery, sunglasses and more. The EyeMed network is a nationwide network of eye care providers at the following retail chains:

- Lenscrafters®
- Pearle Vision®
- Target Optical®
- Sears Optical® locations
- JCPenney Optical

In addition, there are thousands of independent eye care providers to choose from.

Weight Management

You can meet your weight loss goals, get healthier and save money with:

- CalorieKing® Program[1] and products
- Jenny Craig®[2] weight loss programs
- Nutrisystem®[3] weight loss meal plans

Aetna Health Connections℠ — Disease Management Program

Aetna's ongoing commitment to improve care for all members includes the Aetna Health Connections℠ Disease Management program which will deliver comprehensive support services for the significant number of people who present with one or more chronic or recurring conditions, or are at high risk of developing additional chronic conditions. While traditional disease management programs focus on delivering education to at-risk members about a specific chronic condition, the Aetna Health ConnectionsSM Disease Management program is based on a holistic, rather than condition-focused, view of each member. Aetna's Disease Management program addresses more than 30 chronic conditions, which often present as co-morbidities, in a holistic fashion.

Aetna's Disease Management program fully integrates powerful, innovative technology with the educational and outreach benefits of a disease management program and has a precise method for identifying appropriate candidates for disease management through the combination of predictive modeling and actionability assessments. Specifically, the patented ActiveHealth Management CareEngine will monitor all members with disease management benefits 100% of the time attempting to identify gaps, errors, omissions or commissions. Regardless of their health status, Aetna's programs and web-based tools are designed to help members become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

Member Health Education Programs

The key to a long, healthy life is developing good health habits and sticking with them. Through the use of educational materials, Aetna's innovative Member Health Education Programs offer health education, preventive care and wellness programs to Plan participants. These programs provide

1 If you are already a CalorieKing member you will need to terminate your current CalorieKing Account and rejoin to receive the Aetna discounted membership price.

2 Plus the cost of food. Plus the cost of shipping,(if applicable). Offer applies to initial enrollment fee only and is valid only at participating Centers and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per Member. No cash value. Restrictions apply.

3 The Aetna discount offers do not apply to any program in which you are already enrolled. To receive the discounted rate, you must wait until your current program ends. If you are enrolled in Auto-Delivery, you must cancel it and then re-enroll to receive the discounted rate.

materials that, in conjunction with care and advice from a physician, help promote a healthy lifestyle and good health.

To obtain information on Member Health Education Programs, call the toll-free number on your ID card or visit **aetna.com/products/health_education.html**.

Adolescent Immunization

Adolescents need to see their doctors regularly for physical exams and screenings and to update immunizations. To reinforce the importance of protecting their children's health, parents of all 11- and 12-year-olds are sent a newsletter that includes examination and immunization schedule recommended for these age groups. This reminder is in the form of a newsletter provided by Merck & Co., Inc.

Preventive Reminders

Influenza, pneumococcal pneumonia and colorectal cancer are serious health threats. Each year, Aetna sends a preventive health care reminder to households with a member who is particularly vulnerable to one or more of these diseases – adults who are age 50 and older, children ages 6-23 months, and people over age 2 with a chronic condition such as asthma, congestive heart failure, or chronic renal failure.

The reminder stresses the importance of receiving vaccines to prevent influenza and pneumococcal pneumonia, as well as completing appropriate colorectal cancer screening.

Informed Health® Line

Informed Health® Line provides eligible Plan participants with telephone access to registered nurses experienced in providing information on a variety of health topics. The nurses encourage informed health care decision making and optimal patient/provider relationships through information and support. However, the nurses do not diagnose, prescribe or give medical advice.

Informed Health Line is available to eligible employees and their families virtually 24 hours per day, 365 days per year from anywhere in the nation. You can call 1-800-556-1555.

Backed by the Healthwise® Knowledgebase™ (a computerized database of over 1900 of the most common health problems) and an array of other online and desk references, the nurses help you understand health issues, treatment options, review specific questions to ask your provider, provide research analyses of treatments and diagnostic procedures, and explain the risks and benefits of various options. The nurses encourage patient/provider interaction by coaching you to give a clear medical history and information to providers and to ask clarifying questions.

Numbers-to-Know™ — Hypertension and Cholesterol Management

Aetna created Numbers To Know™ to promote blood pressure and cholesterol monitoring. The Numbers To Know mailer is sent to Plan participants who are targeted by selected diagnoses within specific age groups. The mailer includes helpful tips on blood pressure and cholesterol management; desirable goals for blood pressure and cholesterol; and a tri-fold wallet card to track blood pressure, total cholesterol, medication and dosage information.

Hypertension and high cholesterol are never "cured" but may be controlled with lifestyle changes and adherence to a treatment plan. You can help to stay "heart healthy" by monitoring your blood pressure and blood cholesterol numbers.

Numbers To Know can help encourage you to understand your illness, monitor your high blood pressure and high cholesterol and work with your physician to develop an appropriate treatment plan.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your physician should call the Aetna precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements found in the Certification for Admissions sections of this document. Organ means solid organ; hemotopoietic stem cell; bone marrow; tissue and CAR-T and T-Cell receptor therapy for FDA approved treatments.

Benefits may vary if an Institute of Excellence (IOE) facility or non-IOE is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will not be covered. Please read each section carefully.

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

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

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- A Non-IOE facility

Your cost share will be lower when you get transplant services from the IOE facility we designate to perform the transplant you need. You may also get transplant services at a non-IOE facility, but your cost share will be higher.

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

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

Covered Transplant Expenses

Covered transplant expenses include the following:

- 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 parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant.
- 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.

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: (1) 180 days from the date of the transplant; or (2) 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.
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.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- 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).

Limitations

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 storage of organs, without intending to use them for immediate transplantation for your existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Women's Health Care

Aetna is focused on the unique health care needs of women. They have designed a variety of benefits and programs to promote good health throughout each distinct life stage, and are committed to educating female Plan participants about the lifelong benefits of preventive health care.

Support for Women With Breast Cancer

Aetna's Breast Health Education Center helps women make informed choices when they've been newly-diagnosed with breast cancer. A dedicated breast cancer nurse consultant provides the following services:

- Breast cancer information
- Second opinion options
- Information about community resources
- Benefit eligibility
- Help with accessing participating providers for:
  - Wigs
  - Lymphedema pumps

Call **1-888-322-8742** to reach Aetna's Breast Health Education Center.

Confidential Genetic Testing for Breast and Ovarian Cancers

Aetna covers confidential genetic testing for Plan participants who have never had breast or ovarian cancer, but have a strong familial history of the disease. Screening test results are reported directly to the provider who ordered the test.

Direct Access for OB/GYN Visits

This program allows a female Plan participant to visit any participating gynecologist for one routine well-woman exam (including a Pap smear) per year, without a referral from her PCP. The Plan also covers additional visits for treatment of gynecological problems and follow-up care, without a PCP referral. Participating general gynecologists may also refer a woman directly for appropriate gynecological services without the patient having to go back to her participating PCP.

If your gynecologist is affiliated with an IDS or provider group, such as an independent practice association (IPA), you may be required to coordinate your care through that IDS or provider group.

Infertility Case Management and Education

Aetna's Infertility Case Management program is a comprehensive education and information resource for women experiencing infertility.

Depending on the plan selected, the program may guide eligible members to a select network of infertility providers for services. If services are covered under the member's benefits plan, the Infertility Case Management unit will issue any necessary authorizations.

Aetna's Infertility Case Management unit is staffed by a dedicated team of registered nurses and infertility coordinators with expertise in all areas of infertility.

Beginning Right Maternity Program™

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

- Educational materials on prenatal care, labor and delivery, postpartum depression and breastfeeding
- Specialized information for Dad or partner
- Web-based materials and access to program services through Women's Health Online
- Care coordination by trained obstetrical nurses
- Access to Smoke-free Moms-to-be® smoking cessation program for pregnant women
- Preterm labor education
- Access to breastfeeding support services

Under the program, all care during your pregnancy is coordinated by your participating obstetrical care provider and program case managers, so there is no need to return to your PCP for referrals. However, your obstetrician will need to request a referral from Aetna for any tests performed outside of the office. To ensure that you are covered, please make sure your obstetrician has obtained this referral before the tests are performed.

Another important feature, Pregnancy Risk Assessment, identifies women who may need more specialized prenatal and/or postnatal care due to medical history or present health status. If risk is identified, the program assists you and your physician in coordinating any specialty care that may be medically necessary.

Enrollment

Enrollment

New Employees

When you are first eligible to enroll in the Plan, you will be given enrollment and benefit information, including an enrollment form. You must complete the enrollment form and return it to your Human Resources representative. If you do not return the form within the required time period, your employer will assume that you have waived coverage, and you will not be allowed to participate in the Plan until the next open enrollment period, unless you have a change in status.

Open Enrollment

The annual open enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. Open enrollment is held each fall, and the elections you make will be in effect January 1 through December 31 of the following calendar year.

Change in Status

You may change coverage any time during the year because of a change in your status. A change in status is:

- Your marriage, divorce, legal separation or annulment;
- The birth or adoption of a child;
- The death of your spouse or child;
- A change in the number of your dependents;
- A change in employment status for you, your spouse or your dependent; or
- The beginning or end of an unpaid leave of absence taken by you or your spouse.

Whenever you have a change in status, you must report the change by completing a change form, available from your Human Resources representative. The completed change form must be given to your Human Resources representative within 31 days of the event. Otherwise, you must wait until the next employer's open enrollment period.

Note

Newborns are covered until the mother is discharged from the facility. All newborns need to be enrolled via an application to the Division of Pensions and Benefits within 60 days of birth to be retro-enrolled back to their date of birth. Dependents of dependents are not covered but in some instance, Aetna will pay bills related to the birth of a grandchild. In order for benefits to be available, the mother must be enrolled as a covered child. Coverage for the grandchild ends when the mother is discharged from the hospital. The grandparent may apply for dependent coverage of the grandchild only if he or she obtains legal custody of the child.

Special Enrollment Period

You and your eligible dependents may be enrolled during special enrollment periods. A special enrollment period may apply when you or your eligible dependent loses other health coverage or when you acquire a new eligible dependent through marriage, birth, adoption, or placement for adoption.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:

You or an eligible dependent may be enrolled during a special enrollment period, if requirements a, b, c, and d are met:

a. you or your eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under the Plan.

b. you or your eligible dependent previously declined coverage under the Plan;

c. you or your eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

- the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or
- the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated because you or your dependent lose eligibility for the coverage or employer contributions towards the other coverage have been terminated.

- Loss of eligibility includes the following:

  - a loss of coverage as a result of legal separation, divorce, or death;
  - termination of employment;
  - reduction in the number of hours of employment;
  - any loss of eligibility after a period that is measured by reference to any of the foregoing;
  - plan ceases to offer coverage to a group of similarly situated individuals;
  - cessation of a dependent's status as an eligible dependent;
  - termination of benefit package;
  - with respect to coverage under Medicaid or an S-CHIP Plan, you or your dependents no longer qualify for such coverage; and

d. you or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.

Loss of eligibility does not include a loss due to failure of you or your dependent to pay premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this Plan Description.

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

- 60 days of the loss of coverage under the other group health plan or other health insurance coverage;
- 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
- 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

The Effective Date of Coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

You or your eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any described in this Summary Plan Description.

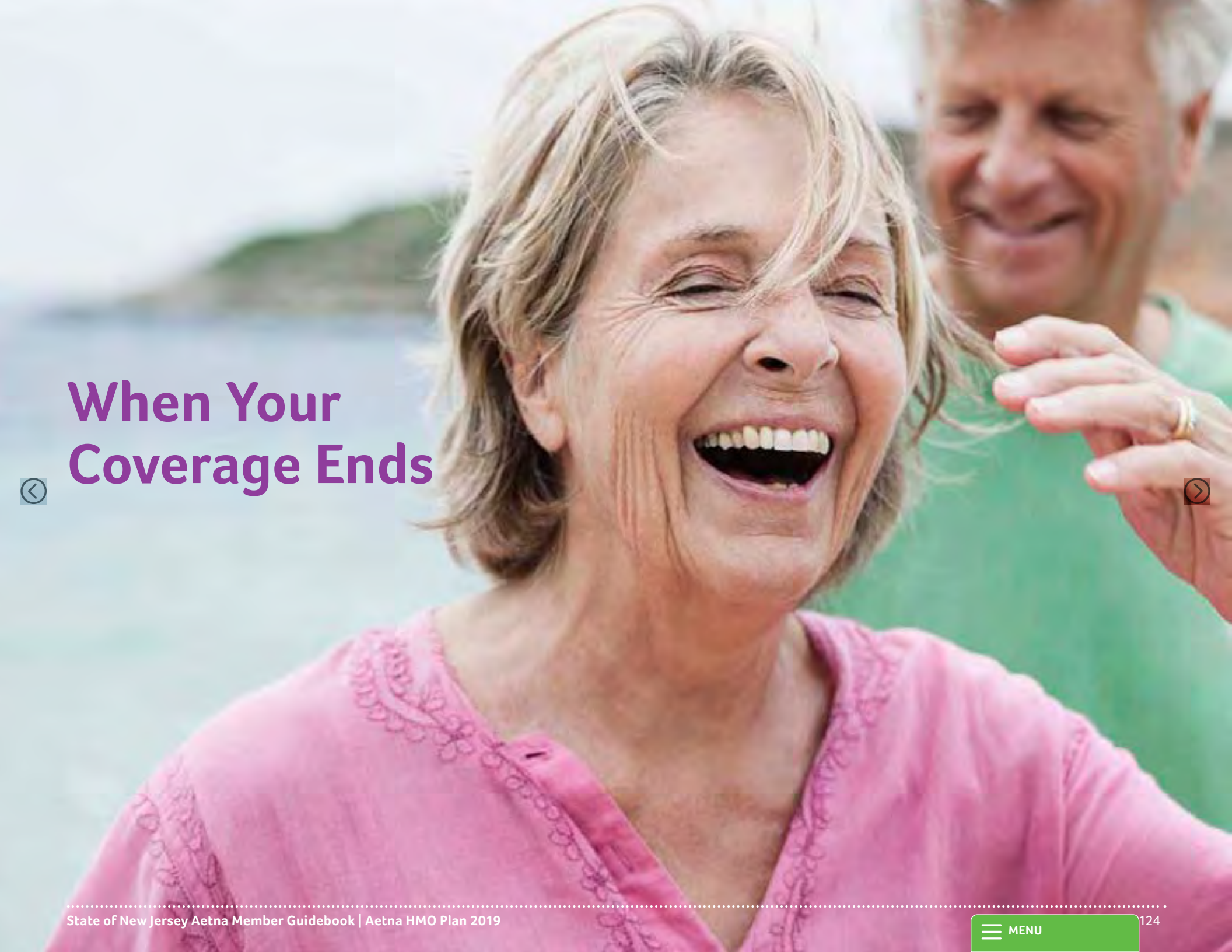
Special Enrollment Period When a New Eligible Dependent is Acquired:

When you acquire a new eligible dependent through marriage, birth, adoption or placement for adoption, the new eligible dependent (as well as you and other eligible dependents, if not otherwise enrolled) may be enrolled during a special enrollment period.

The special enrollment period is a period of 90 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the Effective Date of Coverage will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent's birth, adoption or placement for adoption, the date of such birth, adoption or placement of adoption.

You or your eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this Summary Plan Description.



When Your Coverage Ends

When Your Coverage Ends

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

When Coverage Ends for Employees

Your coverage will end if:

- You voluntarily terminate coverage;
- Your employment terminates;
- You are no longer eligible for coverage;
- You do not make the required contributions;
- You become covered under another health care plan offered by your employer; or
- The Plan is discontinued.

Your Proof of Prior Medical Coverage

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of creditable coverage when your employment ends. This certificate proves that you were covered under this plan when you were employed. Ask your employer about the certificate of creditable coverage.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- Your coverage ends for any of the reasons listed above;
- You die;
- Your dependent is no longer eligible for coverage;
- Your payment for dependent coverage is not made when due; or
- Dependent coverage is no longer available under the Plan.

Continuing Your Health Care Coverage

Continuing Coverage for Dependent Students on Medical Leave of Absence

If your dependent child who is eligible for coverage and enrolled in this plan by reason of his or her status as a full-time student at a postsecondary educational institution ceases to be eligible due to:

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student, resulting from a serious illness or injury, such child's coverage under this plan may continue. Coverage under this continuation provision will end when the first of the following occurs:
  - The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
  - Your dependent child's coverage would otherwise end under the terms of this plan;
  - Dependent coverage is discontinued under this plan; or
  - You fail to make any required contribution toward the cost of this coverage.

To be eligible for this continuation, the dependent child must have been enrolled in this plan and attending school on a full-time basis immediately before the first day of the leave of absence.

To continue your dependent child's coverage under this provision you should notify your employer as soon as possible after your child's leave of absence begins or the change in his or her status as a full-time student. Aetna may require a written certification from the treating physician which states that the child is suffering from a serious illness or injury and that the resulting leave of absence (or change in full-time student status) is medically necessary.

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

At the end of the year your dependent reaches age 26, the New Jersey Division of Pensions and Benefits will automatically terminate their existing coverage as required by Health Care Reform. If the child is physically and/or mentally unable to provide for him- or herself, the member can request a Continuance for Dependent with Disabilities application from the Division of Pensions and Benefits.

The form and proof of the child's condition must be received by the Division of Pensions and Benefits, Health Benefits Bureau, no later than 31 days after the date coverage would normally end. Since coverage for over age children ends on December 31 of the year they turn 26, you have until January 31 to file the Continuance for Dependent with Disabilities form. To obtain this form, call the Division of Pensions and Benefits at **(609) 292-7524**, or write to: Division of Pensions and Benefits Health Benefits Benefits Bureau, PO Box 299, Trenton, NJ 08625-0299.

The Continuance for Dependent with Disabilities form includes a section to be completed by a physician describing the dependent's disability. The Medical Review Board must assess each case, and the Board will often request that the member provide additional medical documentation that the Board finds necessary to make an informed determination.

If the Medical Review Board determines that the dependent child is eligible for continued coverage, it may continue only while (1) you remain covered through the SHBP and SEHBP; and (2) the child continues to be disabled; and (3) the child is unmarried; and (4) the child lives with you and remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage and complete the Continuance for Dependents Disability form.

Aetna and The Division of Pensions and Benefits 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.

Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below, but, with respect to medical benefits, only as to expenses incurred in connection with the injury or illness that caused the total disability. To find out why and when your coverage may end, please refer to When Coverage Ends.

"Totally disabled" means that because of an injury or illness:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage

Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, but only for the condition that caused the disability, for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

COBRA Continuation of Coverage

You and your dependents have the right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to continue medical coverage under certain circumstances (called "qualifying events") when you would otherwise lose coverage. To do so, you must pay up to 102% of the full regular cost of coverage.

Continuation of Coverage Following Termination of Employment or Loss of Eligibility

You and your covered family members are eligible to continue coverage for up to 18 months if:

- You leave your employer for any reason other than gross misconduct; or
- You are no longer eligible because your working hours are reduced.

You may elect to continue coverage for yourself and your dependents, or your dependents may each elect to continue their own coverage.

If you or your dependent is disabled, as defined by the Social Security Administration, at the time of the qualifying event or becomes disabled within 60 days of the event, you may be entitled to an extra 11 months of coverage, for a total of 29 months. You must notify your Human Resources representative of the disability before the end of the original 18-month period to receive the extension, and you must pay up to 150% of the full cost of coverage for every month after the 18th month. Coverage may be continued for the disabled individual and for any family member for whom coverage is already being continued under COBRA, as well as for your newborn or newly adopted child who was added after the date COBRA continuation began. COBRA continuation of benefits will end on the first day of the month that begins more than 30 days after the final determination under Title II or XVI of the Social Security Act that the disabled individual is no longer disabled.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights. Below you will find the qualifying events and a summa ry of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months
You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

Continuation of Coverage Due to Other Qualifying Events

Your eligible dependents can continue coverage for up to 36 months if coverage would otherwise cease because:

- You die;
- You are divorced;
- You stop making contributions for a spouse from whom you are legally separated;
- You become entitled to Medicare; or
- A covered child is no longer eligible under the Plan.

If one of the above events occurs while you or a covered dependent have already continued coverage due to the termination of your employment or your loss of eligibility, your dependent may extend coverage beyond the original 18-month continuation period, but for no more than a total of 36 months from the date coverage would originally have ended.

Applying for COBRA Continuation

Your Human Resources representative will give you information about how to continue COBRA coverage at the time you become eligible.

You must inform your employer of any status changes that would make your dependents eligible for COBRA coverage within 60 days of the later to occur of:

- The occurrence of the event; and
- The date coverage would terminate due to the event.

To ensure that there is no break in coverage, the election to continue coverage must be made within 60 days of:

- The date coverage would terminate due to the event; or
- The date your employer informs your dependents of their right to continue coverage;

whichever happens later.

If you do not make your election within 60 days, you will lose your COBRA continuation rights.

When COBRA Continuation Coverage Ends

Continuation coverage will end on the earliest date that:

- The COBRA continuation period expires.
- You or your family members do not make the required contributions.
- You or your family members become covered under another group health plan, unless that plan contains a provision that restricts the payment of benefits for a pre-existing condition. Once the pre-existing condition clause of the new plan ceases to apply, your COBRA coverage will cease.
- You or your family members become enrolled in Medicare. (Coverage could continue for those individuals not eligible for Medicare for up to 36 months from the original qualifying event, provided those family members otherwise remain eligible.)
- Your employer terminates this health plan.

Claims

Coordination of Benefits

If you have coverage under other group plans, the benefits from the other plans will be taken into account if you have a claim. This may mean a reduction in benefits under the Plan.

Benefits available through other group plans and/or no-fault automobile coverage will be coordinated with the Plan. "Other group plans" include any other plan of dental or medical coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, whether or not the plan is insured; and
- "No-fault" and traditional "fault" auto insurance, including medical payments coverage provided on other than a group basis, to the extent allowed by law.

To find out if benefits under the Plan will be reduced, Aetna must first determine which plan pays benefits first. The determination of which plan pays first is made as follows:

- The plan without a coordination of benefits (COB) provision determines its benefits before the plan that has such a provision.
- The plan that covers a person other than as a dependent determines its benefits before the plan that covers the person as a dependent. If the person is eligible for Medicare and is not actively working, the Medicare Secondary Payer rules will apply. Under the Medicare Secondary Payer rules, the order of benefits will be determined as follows:
  - The plan that covers the person as a dependent of a working spouse will pay first;
  - Medicare will pay second; and
  - The plan that covers the person as a retired employee will pay third.
- Except for children of divorced or separated parents, the plan of the parent whose birthday occurs earlier in the calendar year pays first. When both parents' birthdays occur on the same day, the plan that has covered the parent the longest pays first. If the other plan doesn't have the parent birthday rule, the other plan's COB rule applies.
- When the parents of a dependent child are divorced or separated:
  - If there is a court decree which states that the parents will 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 parent birthday rule, immediately above, applies.
  - If a court decree gives financial responsibility for the child's medical, dental or other health care expenses to one of the parents, the plan covering the child as that parent's dependent determines its benefits before any other plan that covers the child as a dependent.
  - If there is no such court decree, the order of benefits will be determined as follows:
    - the plan of the natural parent with whom the child resides,
    - the plan of the stepparent with whom the child resides,
    - the plan of the natural parent with whom the child does not reside, or
    - the plan of the stepparent with whom the child does not reside.
- If an individual has coverage as an active employee or dependent of such employee, and also as a retired or laid-off employee, the plan that covers the individual as an active employee or dependent of such employee is primary.
- The benefits of a plan which covers a person under a right of continuation under federal or state laws will be determined after the benefits of any other plan which does not cover the person under a right of continuation.

- If the above rules do not establish an order of payment, the plan that has covered the person for the longest time will pay benefits first.

If it is determined that the other plan pays first, the benefits paid under this Plan will be reduced. Aetna will calculate this reduced amount as follows:

- The amount normally reimbursed for covered benefits under this Plan, less
- Benefits payable from your other plan(s).

If your other plan(s) provides benefits in the form of services rather than cash payments, the cash value of the services will be used in the calculation.

Subrogation and Right of Recovery Provision

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 injuries, illness or condition, including the liability insurer of such party, or any insurance carrier providing medical expense 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.

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to 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 injuries, illness, to the full extent of benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury or illness, 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 or illness, up to and including the full amount the Covered Person receives from all Responsible Parties. 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 or illness, he or she will serve as a constructive trustee over the fund that constitutes such payment. Failure to hold such fund in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Further, the Plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment, or otherwise, that a Covered Person receives from Responsible Party as a result of the Covered Person's illness, injuries, or condition.

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 the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

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 or non-economic damages only.

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 attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person 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.

In the event that any claim is made that any part of this 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.

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. Please note that coordination with your auto coverage may be impacted by certain special plan provisions for the SHBP/SEHBP.

Claims, Appeals and External Review

Filing Health Claims under the Plan

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

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

Urgent Care Claims

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

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

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

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

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

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

Ongoing Course of Treatment

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

Health Claims – Standard Appeals

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

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

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

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

Exhaustion of Internal Appeals Process

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

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

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

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

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

Full and Fair Review of Claim Determinations and Appeals

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

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

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

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

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

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

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

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action, if applicable.

Health Claims – Voluntary Appeals

External Review

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

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

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

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

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

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

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

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

Request for External Review

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

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

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

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

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

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

Referral to ERO

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

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

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

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

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

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

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

Referral of Expedited Review to ERO

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

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

Member Services

Member Services Department

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently.

Call the Member Services toll-free number on your ID card at 1-877-StateNJ or 1-877-782-8365 to:

- Ask questions about benefits and coverage;
- Notify Aetna of changes in your name or telephone number;
- Change your PCP; or
- Notify Aetna about an emergency.

Please call your PCP's office directly with questions about appointments, hours of service or medical matters.

Internet Access

You can access Aetna on the internet at **aetna.com/members/member_services.html** to conduct business with the Member Services department electronically.

When you visit the Member Services site, you can:

- Find answers to common questions;
- Change your PCP;
- Order a new ID card; or
- Contact the Member Services department with questions.

Please be sure to include your ID number, Social Security number and e-mail address.

Clinical Policy Bulletins

Aetna uses Clinical Policy Bulletins (CPBs) as a guide when making clinical determinations about health care coverage. CPBs are written on selected clinical issues, especially addressing new technologies, new treatment approaches, and procedures. The CPBs are posted on Aetna's website at **Aetna.com**.

Aetna Member Website

In one easy-to-use website, you can perform a variety of self-service functions and take advantage of a vast amount of health information from Aetna.
Access the Aetna website at **aetna.com** or **aetnastatenj.com** there is link to the Member website.

With Aetna, you can:

- Print instant eligibility information
- Request a replacement ID card
- Select a physician who participates in the Aetna network
- Check the status of a claim
- Link to a voluntary Health Risk Assessment tool
- Use the hospital comparison tool to compare hospital outcome information for medical care provided by hospitals in your area
- Estimate the cost of common health care services
- Receive personalized health and benefits messages
- Contact Aetna Member Services

Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you have a right to:

- Get up-to-date information about the doctors and hospitals participating in the Plan.
- Obtain primary and preventive care from the PCP you chose from the Plan's network.
- Change your PCP to another available PCP who participates in the Aetna network.
- Obtain covered care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness.
- Be told by your doctors how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up doctor 24 hours a day, every day.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Know that your doctor cannot be penalized for filing a complaint or appeal.
- Know how the Plan decides what services are covered.
- Know how your doctors are compensated for the services they provide. If you would like more information about Aetna's physician compensation arrangements, visit their website at **Aetna.com**. Select DocFind from the drop-down menu under Quick Tools, then under "How do I learn more about:" select the type of plan you're enrolled in.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about copayments and fees you must pay.
- Be told how to file a complaint, grievance or appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.
- Obtain your doctor's help in decisions about the need for services and in the grievance process.
- Suggest changes in the Plan's policies and services.

As a Plan participant, you have the responsibility to:

- Choose a PCP from the Plan's network and form an ongoing patient-doctor relationship.
- Help your doctor make decisions about your health care.
- Tell your PCP if you do not understand the treatment you receive and ask if you do not understand how to care for your illness.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Consult with your PCP for non-emergency referrals to specialist or hospital care.
- See the specialists your PCP refers you to.

- Make sure you have the appropriate authorization for certain services, including inpatient hospitalization and out-of-network treatment.
- Call your PCP before getting care at an emergency facility, unless a delay would be detrimental to your health.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers before getting care from them.
- Pay the copayments and coinsurance required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Promptly follow the Plan's grievance procedures if you believe you need to submit a grievance.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know the copayments and what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

There may be occasions when you are not able to make decisions about your medical care. An Advance Directive can help you and your family members in such a situation.

What Is an Advance Directive?

An Advance Directive is generally a written statement that you complete in advance of serious illness that outlines how you want medical decisions made.

If you can't make treatment decisions, your physician will ask your closest available relative or friend to help you decide what is best for you. But there are times when everyone doesn't agree about what to do. That's why it is helpful if you specify in advance what you want to happen if you can't speak for yourself. There are several kinds of Advance Directives that you can use to say what you want and whom you want to speak for you. The two most common forms of an Advance Directive are:

- A Living Will; and
- A Durable Power of Attorney for Health Care.

What Is a Living Will?

A Living Will states the kind of medical care you want, or do not want, if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living.

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition. If you write a living will, give a copy to your PCP.

What Is a Durable Power of Attorney for Health Care?

A Durable Power of Attorney for Health Care is a document giving authority to make medical decisions regarding your health care to a person that you choose. The Durable Power of Attorney is planned to take effect when you can no longer make your own medical decisions.

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad. If you write a Durable Power of Attorney for Health Care, give a copy to your PCP.

Who Decides About My Treatment?

Your physicians will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatments you want. You can say "No" to any treatment you don't want — even if the treatment might keep you alive longer.

How Do I Know What I Want?

Your physician must tell you about your medical condition and about what different treatments can do for you. Many treatments have side effects, and your doctor must offer you information about serious problems that medical treatment is likely to cause you. Often, more than one treatment might help you — and people have different ideas about which is best. Your physician can tell you which treatments are available to you, but they can't choose for you. That choice depends on what is important to you.

How Does the Person Named in My Advance Directive Know What I Would Want?

Make sure that the person you name knows that you have an Advance Directive and knows where it is located. You might consider the following:

- If you have a Durable Power of Attorney, give a copy of the original to your "agent" or "proxy." Your agent or proxy is the person you choose to make your medical decisions when you are no longer able.
- Ask your PCP to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet that states that you have an Advance Directive and where it is located, and who your agent or proxy is, if you have named one.

Who Can Fill Out the Living Will or Advance Directive Form?

If you are 18 years or older and of sound mind, you can fill out this form. You do not need a lawyer to fill it out.

Whom Can I Name to Make Medical Treatment Decisions When I'm Unable to Do So?

You can choose an adult relative or friend you trust to be your agent or proxy, and to speak for you when you're too sick to make your own decisions.

There are a variety of living will forms available, or you can write your wishes on a piece of paper. If necessary, your doctor and family can use what you write to help make decisions about your treatment.

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Will I Be Treated If I Don't Execute an Advance Directive?

Absolutely. We just want you to know that if you become too ill to make decisions, someone else will have to make them for you. With an Advance Directive, you can instruct others about your wishes before becoming unable to do so.

Can I Change My Mind After Writing an Advance Directive?

Yes. You may change your mind or cancel these documents at any time as long as you are competent and can communicate your wishes to your physician, your family and others who may need to know.

What Is the Plan's Policy Regarding Advance Directives?

We share your interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future and urge you to discuss these topics with your PCP, family, friends, and other trusted, interested people.

You are not required to execute an Advance Directive. If you choose to complete an Advance Directive, it is your responsibility to provide a copy to your physician and to take a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.

How Can I Get More Information About Advance Directives?

Call the Member Services toll-free number on your ID card.

Federal Notices

Federal Notices

This section describes laws and plan provisions that apply to reproductive and women's health issues.

The Newborns' and Mothers' Health Protection Act

Federal law generally prohibits restricting benefits for hospital lengths of stay to less than 48 hours following a vaginal delivery and less than 96 hours following a caesarean section. However, the plan may pay for a shorter stay if the attending provider (physician, nurse midwife or physician assistant) discharges the mother or newborn earlier, after consulting with the mother.

Also, federal law states that plan benefits may not, for the purpose of benefits or out-of-pocket costs, treat the later portion of a hospital stay in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Finally, federal law states that a plan may not require a physician or other health care provider to obtain authorization of a length of stay up to 48 hours or 96 hours, as described above. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

The Women's Health and Cancer Rights Act

In accordance with the Women's Health and Cancer Rights Act, this Plan covers the follow procedures for a person receiving benefits for an appropriate mastectomy:

- Reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to create a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy.

For answers to questions about the plan's coverage of mastectomies and reconstructive surgery, call Aetna's Member Services at the number shown on your ID card.

Important Health Care Reform Information

Some language changes in response to recent changes to preventive services coverage and women's preventive health coverage under the Federal Affordable Care Act (ACA) may not be included in the enclosed booklet. This may be because the language is still pending regulatory review and approval. However, please note that Aetna is administering medical and outpatient prescription drug coverage in compliance with the applicable components of the ACA.

The following is a summary of the recent changes to preventive services coverage and women's preventive health coverage under the ACA that applies to non-grandfathered plans that are not otherwise exempt from the requirements. Preventive services, as required by ACA, will be paid without cost-sharing such as payment percentages, copays and deductibles.

For details on any benefit maximums and the cost sharing under your plan, call your Aetna contact number on the back of your ID card.

1. An annual routine physical exam for covered persons through age 21.

2. For covered females:

- Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
- Screening and counseling services, such as:
  - Interpersonal and domestic violence;
  - Sexually transmitted diseases; and
  - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older and limited to once every three years.
- A routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

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

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

Benefits under your plan may be subject to visit maximums.

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

Benefits under your plan may be subject to visit maximums.

5. Screening and counseling services to aid you to stop the use of tobacco products. Coverage includes:

- Preventive counseling visits;
- Treatment visits, class visits, and
- Tobacco cessation prescription.

Benefits under your plan may be subject to visit maximums.

6. Prenatal care received by a pregnant female. Coverage is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).
7. Comprehensive lactation support, (assistance and training in breast feeding), and counseling services provided by a certified lactation support provider, in a group or individual setting, to females during pregnancy and in the post partum period.

The rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk), and the purchase of the accessories and supplies needed to operate the item. 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.

Benefits under your plan may be subject to maximums.

8. For females with reproductive capacity, coverage includes:

- FDA-approved contraceptive methods including certain FDA-approved generic drugs, implantable devices, sterilization procedures and patient

education and counseling for women with reproductive capacity.

- Counseling services provided by a physician in either a group or individual setting on contraceptive methods. Benefits may be subject to visit maximums.
- Female voluntary sterilization procedures and related services and supplies including tubal ligation and sterilization implants. Coverage does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
- FDA-approved female generic emergency contraceptive methods that are prescribed by your physician. The prescription must be submitted to the pharmacist for processing.

Additional exemptions may apply to plans that are sponsored by religious employers or religious organizations and meet certain criteria which exempt the health plan from the federal requirement to provide coverage for contraceptive services.

The drug list is subject to change. Visit "Medication Search" on your secure member website at **Aetna.com** for the most up-to-date information on drug coverage for your plan.

Choice Of Provider

If your Aetna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health coverage designates a primary care provider automatically, then until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

If your Aetna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Aetna contact number on the back of your ID card.

Amendment or Termination of the Plan

Your employer has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified.

The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any nonforfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the HMO Plan administered by Aetna Life Insurance Company, effective January 1, 2017. The plan description has been designed to provide a clear and understandable summary of the Plan

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call **1-888-370-4526**.

Smartphone or Tablet

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

Non-Discrimination

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

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator,
PO Box 14462, Lexington, KY 40512,
1-800-648-7817, TTY 711,
Fax 859-425-3379,
CRCoordinator@aetna.com.

California HMO/HNO Members:
Civil Rights Coordinator,
PO Box 24030 Fresno CA, 93779,
1-800-648-7817, TTY 711,
Fax 860-262-7705,
CRCoordinator@aetna.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F,
HHH Building, Washington, D.C. 20201,
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

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

Language Assistance

TTY: 711

For language assistance in English call **1-888-370-4526** at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 1-800-370-4526. (Spanish)

欲取得繁體中文語言協助，請撥打 1-800-370-4526，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 1-800-370-4526 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-370-4526 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee sh7k1 a'doowo[n7n7zingo Din4 k'ehjí koj8í t'áá j77k'e h0lneí 1-800-370-4526 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-370-4526 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-800-370-4526. (Albanian)

በ አማርኛ የቋንቋ እገዛ ለማግኘት በ 1-800-370-4526 በነጻ ይደውሉ (Amharic)

(Arabic) .1-800-370-4526 الاتصال على الرقم المجاني للمساعدة في (اللغة العربية)، الرجاء

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-370-4526 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-370-4526 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-370-4526 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-800-370-4526 -তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-370-4526 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-800-370-4526. (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-800-370-4526 sin gåstu. (Chamorro)

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(Chahta) anumpa ya̲ apela a chi I̲ pa̲ya hinla 1-800-370-4526. (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-370-4526 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-370-4526. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-370-4526 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-370-4526 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-370-4526 પર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-370-4526. Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-800-370-4526 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-370-4526. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-800-370-4526 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-370-4526 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-370-4526 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-370-4526. (Italian)

日本語で援助をご希望の方は、1-800-370-4526 まで無料でお電話ください。(Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိဉ်အဂီၤ် ကျိဉ် ကိး 1-800-370-4526 လၢတအိဉ်ဒီးတၢ်လၢာ်ဘူဉ်လၢာ်စုးဘာ (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-370-4526 번으로 전화해 주십시오. (Korean)

Bɛ́ m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-800-370-4526 (Kru-Bassa)

(Kurdish) .به 1-800-370-4526 خۆڕایی پەیوەندی بکەن ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 4526 بۆ وەرگرتنی

ຖ້າທ່ານຕ້ອງການຄວາມ ຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-800-370-4526 ໂດຍບໍ່ເສຍ ຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-800-370-4526 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-370-4526 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-370-4526 ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជាភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-370-4526 मा फोन गनुर्होस् । (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-370-4526 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-800-370-4526 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-800-370-4526 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

(Persian) بدون هیچ هزینه ای تماس بگیرید. انگلیسی راهنمایی به زبان فارسی با شماره 1-877-459-6604 برای

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-370-4526. (Polish)

Para obter assistência linguística em português ligue para o 1-800-370-4526 gratuitamente. (Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-370-4526 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-800-370-4526 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-370-4526. (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le1-800-370-4526 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-370-4526. (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-370-4526. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-370-4526 bila malipo. (Swahili)

(Assyrian-Syriac) .ܫܘܦܪ 1-800-370-4526

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-800-370-4526 కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-800-370-4526 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni1-800-370-4526 ‘o ‘ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-370-4526 nge esapw kamé ngonuk. (Trukese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-370-4526. (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-370-4526. (Ukrainian)

(Urdu) اُردو میں لسانی معاونت کے لیے 1-800-370-4526 پر مفت کال کریں۔

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-370-4526. (Vietnamese)

(Yiddish). 1-877-459-6604 פריי פון אפצאל
פאר שפראך הילף אין אידיש רופט

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-370-4526 lái san owó kankan rárá. (Yoruba)

Glossary

Glossary

A

Advanced Reproductive Technology ("ART") – means:

a. in vitro fertilization (IVF);

b. gamete intra-fallopian transfer (GIFT);

c. zygote intra-fallopian transfer (ZIFT);

d. cryopreserved embryo transfers; or

e. intra-cytoplasmic sperm injection (ICSI) or ovum microsurgery.

Annual out-of-pocket maximum – means the maximum amount a Plan participant must pay toward covered expenses in a calendar year. Once you reach your annual out-of-pocket maximum, the Plan pays 100% of covered expenses for the remainder of the calendar year. and coinsurance amounts apply toward the annual out-of-pocket maximum.

Certain expenses do not apply toward the annual out-of-pocket maximum:

- Charges for services that are not covered by the Plan.
- Copayments for prescription drugs.

B

Behavioral Health Provider – means a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

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

Brand Name Drug – means a prescription drug that is protected by trademark registration.

C

Coinsurance – means the sharing of certain covered expenses by the Plan and the Plan participant. For example, if the Plan covers an expense at 100% (the Plan's coinsurance), your coinsurance share is 20%.

Copayment (copay) – means the fee that must be paid by a Plan participant to a participating provider at the time of service for certain covered expenses and benefits, as described in the "Schedule of Benefits."

Cosmetic surgery – means any surgery or procedure that is not medically necessary and whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not:

- Restore bodily function;
- Correct a diseased state, physical appearance or disfigurement caused by an accident or birth defect; or
- Correct or naturally improve a physiological function.

Covered services and supplies (covered expenses) – means the types of medically necessary services and supplies described in "Your Benefits."

Creditable Coverage. – Coverage of the Plan participant under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, including coverage received under a plan established or maintained by a foreign country or political subdivision as well as one established and maintained by the government of the United States, any health benefit plan under section 5(e) of the Peace Corps Act and the State Children's Health Insurance Program (S-Chip).

Creditable Coverage does not include coverage only for accident; Workers' Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided in a separate policy.

Custodial care – means any service or supply, including room and board, which:

- Is furnished mainly to help you meet your routine daily needs; or
- Can be furnished by someone who has no professional health care training or skills; or
- Is at a level such that you have reached the maximum level of physical or mental function and are not likely to make further significant progress.

D

Deductible – means the amount of covered, self-referred expenses that a Plan participant must pay each calendar year before the Plan begins paying benefits.

Detoxification – means the process whereby an alcohol-intoxicated, alcohol-dependent or drug-dependent person is assisted in a facility licensed by the state in which it operates, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factor, or alcohol in combination with drugs as determined by a licensed physician, while keeping physiological risk to the patient at a minimum.

Durable medical equipment (DME) – means equipment determined to be:

- Designed and able to withstand repeated use;
- Made for and used primarily in the treatment of a disease or injury;
- Generally not useful in the absence of an illness or injury;
- Suitable for use while not confined in a hospital;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

E

Emergency – means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

With respect to emergency services furnished in a hospital emergency department, the Plan does not require prior authorization for such services if you arrive at the emergency medical department with symptoms that reasonably suggest an emergency condition, based on the judgment of a prudent layperson, regardless of whether the hospital is a participating provider. All medically necessary procedures performed during the evaluation (triage and treatment of an emergency medical condition) are covered by the Plan.

Experimental or investigational – means services or supplies that are determined by Aetna to be experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There are not sufficient outcomes data available from controlled clinical trials

published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol(s) used by the treating facility or the protocol(s) 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 for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the medical community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

G

Generic Drug – means a prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

H

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

Home health services – means those items and services provided by participating providers as an alternative to hospitalization, and approved and coordinated in advance by Aetna.

Hospice care – means a program of care t hat is:

- Provided by a hospital, skilled nursing facility, hospice or duly licensed hospice care agency;
- Approved by Aetna; and
- Focused on palliative rather than curative treatment for a Plan participant who has a medical condition and a prognosis of less than 6 months to live.

Hospital – means an institution rendering inpatient and outpatient services, accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna as meeting reasonable standards. A hospital may be a general, acute care, rehabilitation or specialty institution.

I

Infertility – means a disease or condition that results in the abnormal function of the reproductive system such that:

- A male is not able to impregnate a female;
- A female under 35 years of age is unable to conceive after two years of unprotected sexual intercourse;
- A female 35 years of age and over is unable to conceive after one year of unprotected sexual intercourse;
- The male or female is determined to be medically sterile; or
- The female is not able to carry a pregnancy to live birth.

Additionally, a female without a male partner may be considered infertile if:

- For females under age 35, she is unable to conceive after at least 24 cycles of donor insemination.
- For females age 35 or older, unable to conceive after at least 12 cycles of donor insemination.

Infertility Case Management – means a program that consists of:

- evaluation of infertile member's medical records to determine whether ART Services are Medically Necessary and are reasonably likely to result in success;
- determination of whether ART Services are Covered Services and Supplies for the member;
- pre-authorization for ART Services by a Participating ART Specialist when ART Services are Medically Necessary, reasonably likely to result in success, and are Covered Services and Supplies; and
- case management for the provision of ART Services for eligible members.

Institute of Excellence (IOE) – This is a facility that is contracted with Aetna to furnish particular services and supplies to you and your covered dependents in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

M

Medical services – means those professional services of physicians or other health professionals, including medical, surgical, diagnostic, therapeutic and preventive services authorized by Aetna.

Medically necessary – means services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards, as described in the "Your Benefits" section of this booklet. To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well-baby care, as determined by Aetna;
- Be a diagnostic procedure, indicated by the health status of the Plan participant, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, as to both the disease or injury involved and your overall health condition;
- Include only those services and supplies that cannot be safely and satisfactorily provided at home, in a physician's office, on an outpatient basis, or in any facility other than a hospital, when used in relation to inpatient hospital services; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining whether a service or supply is medically necessary, Aetna will consider:

- Information provided on your health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved;
- The opinion of the attending physicians, which has credence but does not overrule contrary opinions; and
- Any other relevant information brought to Aetna's attention.

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

- Services or supplies that do not require the technical skills of a medical, mental health or dental professional;
- Custodial care, supportive care or rest cures;
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, any person caring for the patient, any person who is part of the patient's family or any health care provider;
- Services or supplies furnished solely because the Plan participant is an inpatient on any day when their disease or injury could be diagnosed or treated safely and adequately on an outpatient basis;
- Services furnished solely because of the setting if the service or supply could be furnished safely and adequately in a physician's or dentist's office or other less costly setting; or
- Experimental services and supplies, as determined by Aetna.

Mental Disorders – means 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.

The following conditions are considered a mental disorder under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Pervasive Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

Morbid Obesity – 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.

O

Outpatient – means:

- A Plan participant who is registered at a practitioner's office or recognized health care facility, but not as an inpatient; or
- Services and supplies provided in such a setting.

P

Partial hospitalization – means medical, nursing, counseling and therapeutic services provided on a regular basis to a Plan participant who would benefit from more intensive services than are offered in outpatient treatment but who does not require inpatient care. Services must be

provided in a hospital or non-hospital facility that is licensed as an alcohol, drug abuse or mental illness treatment program by the appropriate regulatory authority.

Participating ART Specialist – means a Specialist who has entered into a contractual agreement with Aetna for the provision of ART Services.

Participating provider – means a provider that has entered into a contractual agreement with Aetna to provide services to Plan participants.

Physician – means a duly licensed member of a medical profession, who is properly licensed or certified to provide medical care under the laws of the state where they practice, and who provides medical services which are within the scope of their license or certificate.

Plan benefits – means the medical services, hospital services, and other services and care to which a Plan participant is entitled, as described in this booklet.

Plan participant – means an employee or covered dependent.

Preexisting Condition – A preexisting condition is an illness or injury for which, [medical advice, diagnosis, care, or treatment was recommended or received] [medical treatment, services, or supplies were received or prescription drugs or medicines were taken prior to your or your eligible dependents' effective date of coverage under your HMO benefits program]. The time used to satisfy any applicable waiting period will be credited to the preexisting condition limitation period. [No waiting period credit will apply to late enrollees.]

Preferred Drug Guide – means a listing of prescription drugs and insulin established by the health plan, that includes both brand name prescription drugs and generic prescription drugs. This list is subject to periodic review and modification by Aetna. Drugs listed on the preferred drug guide are covered under the prescription drug plan, which copayments as shown in the "Schedule of Benefits".

Preferred Drug Guide Exclusions List – means a list of prescription drugs in the preferred drug guide that are identified as excluded under the plan. This list is subject to periodic review and modification by Aetna.

Primary Care Physician (PCP) – means a participating physician who supervises, coordinates, and provides initial care and basic medical services as a general or family care practitioner or, in some cases, as an internist or a pediatrician, to Plan participants; initiates their referral for specialist care; and maintains continuity of patient care.

Provider – means a physician, health professional, hospital, skilled nursing facility, home health agency, or other recognized entity or person licensed to provide hospital or medical services to Plan participants.

Psychiatric Physician – means a physician who:

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

R

Referral – means specific written or electronic direction or instruction from a Plan participant's PCP, in conformance with Aetna's policies and procedures, which directs the Plan participant to a participating provider for medically necessary care.

Residential Treatment Facility (Mental Disorders) – means 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).
- 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 (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Residential Treatment Facility (Substance Abuse) – means 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/7days 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).
- 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 (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational

services, schooling or any such related or similar program, including therapeutic programs within a school setting.

- 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 abuse professionals 24 hours per day/7 days a week.

S

Service area – means the geographic area, established by Aetna and approved by the appropriate regulatory authority, in which a Plan participant must live or work or otherwise meet the eligibility requirements in order to be eligible as a participant in the Plan.

Skilled nursing facility – means an institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a skilled nursing facility, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by Aetna to meet the reasonable standards applied by any of the aforesaid authorities.

Specialist – means a physician who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Substance abuse – means any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

T

Terminal illness – means an illness of a Plan participant, which has been diagnosed by a physician and for which they have a prognosis of six (6) months or less to live.

U

Urgent medical condition – means a medical condition for which care is medically necessary and immediately required because of unforeseen illness, injury or condition, and it is not reasonable, given the circumstances, to delay care in order to obtain the services through your home service area or from your PCP.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Aetna Life Insurance Company and your employer. The information herein is believed accurate as of the date of publication and is subject to change without notice.

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