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State of New Jersey Member Guidebook Aetna Liberty Plan

For Employees Enrolled In The
State Health Benefits Program
Department of the Treasury
Division of Pensions and Benefits

Plan Year 2018



AetnaStateNJ.com

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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 Liberty 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).

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. 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 Liberty 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

The screenshot shows the 'Aetna Liberty Plan: Overview' page. Annotations include:

- Live Link:** Points to the URL AetnaStateNJ.com in the text.
- Next Page:** Points to the right edge of the page.
- Previous Page:** Points to the left edge of the page.
- Menu:** Points to the 'MENU' button at the bottom right of the page.

Aetna Liberty Plan: Overview

Summary of Benefits: Aetna Liberty Plan

The Aetna Liberty plan provides access to covered services and supplies through a network of health care providers and facilities. The plan is designed to lower your out-of-pocket costs when you use Tier 1 network providers and facilities for covered expenses.

Tier 1 and Tier 2 Network Providers

In addition to the Tier 1 network providers described above, this Aetna Liberty plan provides preferred benefit coverage and access to certain covered services and supplies through a network of health care providers and facilities that are unique to your plan.

The network has been divided into two groups. The two groups of network providers are called Tier 1 network providers and Tier 2 network providers in this plan. This plan is designed to lower your out-of-pocket costs when you Tier 1 network providers for covered expenses.

Both groups of network providers are identified in the on-line version of the directory via DocFind® at AetnaStateNJ.com. Please be sure to look at the appropriate directory that applies to your plan, since different Aetna plans use different networks of providers. Your plan includes different benefit levels based upon the type of network provider that you use Tier 1 or Tier 2 providers.

Important Note

If you live in an area with a Tier 1 network, for maximum savings, you will want to seek services at a Tier 1 network provider for care. If you select a Tier 2 network provider for your care, your out-of-pocket expenses will be higher than if you selected a Tier 1 network provider. Carefully read the details on cost-sharing provided later in this Schedule of Benefits.

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Eligibility & Important Plan Information



Eligibility & Important Plan Information

Active Employee Eligibility

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to coverage, etc. must be presented through your employer to the SHBP. 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 postretirement 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. 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. 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 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 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 (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 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.

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 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;

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.

Aetna Liberty Plan Overview



Aetna Liberty Plan: Overview

Summary of Benefits: Aetna Liberty Plan

The Aetna Liberty plan provides access to covered services and supplies through a network of health care providers and facilities. The plan is designed to lower your out-of-pocket costs when you use Tier 1 network providers and facilities for covered expenses.

Tier 1 and Tier 2 Network Providers

In addition to the Tier 1 network providers described above, this Aetna Liberty plan provides preferred benefit coverage and access to certain covered services and supplies through a network of health care providers and facilities that are unique to your plan.

The network has been divided into two groups. The two groups of network providers are called Tier 1 network providers and Tier 2 network providers in this plan. This plan is designed to lower your out-of-pocket costs when you use Tier 1 network providers for covered expenses.

Both groups of network providers are identified in the on-line version of the directory via DocFind® at [AetnaStateNJ.com](https://www.aetna.com/docfind). Please be sure to look at the appropriate directory that applies to your plan, since different Aetna plans use different networks of providers. Your plan includes different benefit levels based upon the type of network provider that you use Tier 1 or Tier 2 providers.

Important Note

If you live in an area with a Tier 1 network, for maximum savings, you will want to seek services at a Tier 1 network provider for care. If you select a Tier 2 network provider for your care, your out-of-pocket expenses will be higher than if you selected a Tier 1 network provider. Carefully read the details on cost-sharing provided later in this Schedule of Benefits.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Calendar Year Deductible *		
Individual Deductible	None	\$1,500
Family Deductible	None	\$3,000
Per Admission Copayment	\$150 per admission	\$150 per admission for hospice services only

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

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

Individual Maximum Out of Pocket Limit:

- For Tier 1 network provider expenses: \$2,500
- For Tier 2 network provider expenses: \$4,500

Family Maximum Out of Pocket Limit:

- For Tier 1 network provider expenses: \$5,000
- For Tier 2 network provider expenses: \$9,000

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Lifetime Maximum Benefit Per Person	Unlimited	Unlimited

Payment percentage or the coinsurance listed in the schedule of benefits below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur. In addition the copayments listed in the following schedule of benefits are the responsibility of the member(s) covered under the plan.

All covered expenses are subject to the calendar year deductible unless otherwise noted in the schedule of benefits below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between Tier 1 network providers and Tier 2 network providers, unless specifically stated otherwise.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Preventive Care Benefits		
Office Visits	Covered at 100% per visit No copay applies	Covered at 100% per visit No copay or deductible applies
<p>Important Note: Covered persons through age 21 are subject to any age and visit preventive care limits provided in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. For additional details, contact your physician or Member Services by visiting AetnaStateNJ.com. You can also contact members services at 1-877-STATENJ.</p> <p>Covered persons ages 22 and over have a maximum of 1 routine preventive care visit per calendar year.</p>		
Immunizations (Performed in a facility or physician's office)	Covered at 100% No copay applies	Covered at 100% No copay or deductible applies
<p>Note: Immunizations for travel are not covered in Tier 1 or Tier 2.</p> <p>Important Note: Preventive care immunizations are subject to any age and visit preventive care limits provided in the comprehensive guidelines supported by the Advisory Committee or Immunization Practices of the Centers for Disease Control and Prevention. For additional details, contact your physician or Member Services by visiting AetnaStateNJ.com. You can also contact member services at 1-877-STATENJ.</p>		
Preventive Care Drugs and Supplements	Please refer to your Prescription Drug Guidebook	Please refer to your Prescription Drug Guidebook
Outpatient Prescription Drugs		
Prescription Drugs	100% (of the recognized charge) prescription or refill No deductibles applies	100% (of the recognized charge) prescription or refill No deductibles applies

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Family Planning Services – Female Contraceptives		
Female contraceptives that are generic prescription drugs		
<ul style="list-style-type: none"> • Oral drugs • Injectable drugs • Vaginal rings • Transdermal contraceptive patches 	<p>100% per prescription or refill</p> <p>No deductible applies</p>	<p>100% per prescription or refill</p> <p>No deductible applies</p>
Female contraceptive devices	<p>100% per prescription or refill</p> <p>No deductible applies</p>	<p>100% per prescription or refill</p> <p>No deductible applies</p>
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	<p>100% per prescription or refill</p> <p>No deductible applies</p>	<p>100% per prescription or refill</p> <p>No deductible applies</p>
Preventive Screening and Counseling Services		
Obesity and/or Healthy Diet Counseling		
Maximum of 26 visits every calendar year (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)*.	<p>Covered at 100% per visit</p> <p>No copay applies</p>	<p>Covered at 100% per visit</p> <p>No copay or deductible applies</p>
Misuse of Alcohol and/or Drugs	<p>Covered at 100% per visit</p> <p>No copay applies</p>	<p>Covered at 100% per visit</p> <p>No copay or deductible applies</p>
Maximum of 5 visits every calendar year*		

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Sexually Transmitted Infections	Covered at 100% per visit	Covered at 100% per visit
Maximum of 2 visits every calendar year*	No copay applies	No copay or deductible applies
Use of Tobacco Products	Covered at 100% per visit	Covered at 100% per visit
Maximum of 8 visits every calendar year*	No copay applies	No copay or deductible applies
Genetic Risk for Breast and Ovarian Cancer	Covered at 100%	Covered at 100%
Precertification required	No copay applies	No copay or deductible applies

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

Well Woman Preventive Care Visits

Office Visits	Covered at 100% per visit	Covered at 100% per visit
Maximum of 1 visit every calendar year - Subject to any age limits guidelines.	No copay applies	No copay or deductible applies

Cancer Screenings

Routine Cancer Screening	Covered at 100% per visit	Covered at 100% per visit
Outpatient	No copay applies	No copay or deductible applies
Lung Cancer Screening	Covered at 100% per visit	Covered at 100% per visit
Maximum 1 screening every calendar year Covered from age 55 years & older	No copay applies	No copay or deductible applies

Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Physician Services		
Primary Care Physician – Office Visits		\$20 copay
Office visits including non-surgery and surgery	\$5 copay	No deductible applies
Specialist – Office Visits		\$30 copay
Office visits including non-surgery and surgery	\$15 copay	No deductible applies
Walk-In Clinic Visit	\$5 copay	\$20 copay No deductible applies
Administration of Anesthesia	Covered at 100% No copay applies	Covered at 80% after deductible
Allergy Injections	Covered at 100% after PCP or Specialist Copay	Covered at 100% after PCP or Specialist copay
Immunizations (When not part of a physical examination)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<p>Important Note: Understanding your visit maximums – Visit maximums are subject to any age; family history and frequency guidelines as set forth in the most current evidence based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration.</p> <p>For details, contact your physician or Member Services team at 1-877-STATENJ.</p>		

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Hearing Services		
Hearing Exam For children through age 15, no coverage for ages 16 and older.	\$15 copay	\$30 copay No deductible applies
Hearing Aids For children through age 15, no coverage for ages 16 and older. Hearing supply maximum of \$1,000 per ear per 24 months	Covered at 100% No copay applies	Covered at 100% No copay or deductible applies
Emergency Medical Services		
Hospital Emergency Facility and Physician	\$100 copay per visit	\$100 copay per visit No deductible applies
Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered
Ambulance (Ground, Air or Water)	Covered at 100% No copay applies	Covered at 100% No copay or deductible applies
Important Note: A separate hospital emergency room copay applies for each visit to an emergency room for emergency care. If you are admitted to a hospital as an inpatient immediately following a visit to an emergency room, your copay is waived. If you are to seek emergency care at a nonparticipating hospital, you will be responsible for a \$100 copay per visit.		
Important Note: Please note that as these providers are not Network Providers and do not have a contract with Aetna, the provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Urgent Care Services		
Urgent Medical Care (At a non-hospital free standing facility)	\$15 copay	\$30 copay No deductible applies
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Complex Imaging Services		
Complex Imaging	\$15 copay	Covered at 80% after deductible
Diagnostic Laboratory Testing		
Diagnostic Labs (Hospital Outpatient)	\$15 copay	Covered at 80% after deductible
Diagnostic Labs (Performed at a Quest Facility or Freestanding Facility)	Covered at 100% per procedure No copay applies	Covered at 100% per procedure No copay or deductible applies
Diagnostic X-Rays - Except Complex Imaging Services		
Diagnostic X-Rays (Hospital Outpatient)	\$15 copay	Covered at 80% after deductible
Diagnostic X-Rays (Performed at Freestanding Facility)	Covered at 100% per procedure No copay applies	Covered at 100% per procedure No copay or deductible applies

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Family Planning		
Comprehensive Lactation Support and Counseling Services (Facility or Office Visits)	Covered at 100% per visit No copay applies	Covered at 100% per visit No copay or deductible applies
Breast Pumps & Supplies	Covered at 100% per item No copay applies	Covered at 100% per item No copay or deductible applies
Important Note: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the Physician Services office visits.		
Family Planning – Voluntary Termination of Pregnancy (Outpatient)		
Performed in a Physician Office	\$5 copay	\$20 copay No deductible applies
Performed in a Specialist Office	\$15 copay	\$30 copay No deductible applies
Performed in another facility	Covered at 100% per procedure No copay applies	Covered at 80% after deductible
Family Planning – Voluntary Sterilization for Males (Outpatient)		
Performed in a Physician Office	\$5 copay	\$20 copay No deductible applies
Performed in a Specialist Office	\$15 copay	\$30 copay No deductible applies
Performed in another facility	Covered at 100% per procedure No copay applies	Covered at 80% after deductible

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
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Family Planning Services – Contraceptive

Female Contraceptive Counseling Services – Office Visits	Covered at 100% per item No copay applies	Covered at 100% per item No copay or deductible applies
Female Contraceptive Devices	Covered at 100% per item No copay applies	Covered at 100% per item No copay or deductible applies
Female Contraceptive Devices and Injectable Medications provided, administered, or removed by a physician during office visits	Covered at 100% per item No copay applies See Important Note Below	Covered at 100% per item No copay or deductible applies See Important Note Below

Important Note: Brand contraceptives covered at plan rate or same as office visit when provided in the office.

Family Planning Services – Nutritional Support

Covered at 100%

No copay or deductible applies for special formulas, infant formula 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.

Family Planning – Voluntary Sterilization for Females

Performed in an inpatient or outpatient facility	Covered at 100% per procedure No copay applies	Covered at 100% per procedure No copay or deductible applies
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Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the Physician Services office visits.

Family Planning

Prenatal Care Office Visits	Covered at 100% per visit	Covered at 100% per visit
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Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Vision Care		
Eye Examinations Maximum of 1 exam every calendar year	\$15 copay	\$30 copay No deductible applies
Outpatient Surgery and Outpatient Benefits		
Outpatient Surgery (Facility charges)	\$150 copay per visit	Covered at 80% per visit/surgical procedure after deductible
Outpatient Surgery (Professional charges)	Covered at 100% No copay applies	Covered at 80% per visit/surgical procedure after deductible
Home Health Care (Outpatient)	\$5 copay per visit	\$5 copay per visit No deductible applies
Private Duty Nursing (Outpatient)	Covered at 100% per visit No copay applies	Covered at 80% per visit after deductible
Inpatient Facility Benefits		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses (Room and Board including maternity)	\$150 per admission copay per visit Maternity - Covered at 100% No Copay applies	Covered at 80% per admission after deductible
Skilled Nursing Inpatient Facility Maximum of 120 days combined between Tier 1 and Tier 2 per calendar year	\$150 per admission copay per visit	Covered at 80% per admission after deductible

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Physician Services for Inpatient Facility and Hospital Visits	Covered at 100% No copay applies	Covered at 80% after deductible
Hospice Benefits		
Hospice Care-Facility Expenses (Room and Board)	Covered at 100% per admission No copay applies	\$150 per admission copay per visit No deductible applies
Hospice Care – Other expenses during stay	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Hospice Outpatient Visits	Covered at 100% per visit No copay applies	Covered at 80% per visit after deductible
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses Maximum of 4 egg retrievals per lifetime.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses		
Expenses for Advanced Reproductive Technology Expenses for Advanced Reproductive Technology (ART) will not be used to satisfy the plan Maximum Out-of-Pocket Limit	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Inpatient Treatment of Mental Disorders		
Hospital Facility Expenses (Room and board)	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Hospital Facility Expenses (Other than room and board)	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Inpatient Residential Treatment Facility	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Inpatient Residential Treatment Facility Physician Services Expenses	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Outpatient Treatment of Mental Disorders		
Outpatient Services	\$15 copay	\$30 copay No deductible applies
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses (Room and board)	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Hospital Facility Expenses (Other than room and board)	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Inpatient Residential Treatment Facility	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible
Inpatient Residential Treatment Facility Physician Services Expenses	Covered at 100% per admission No copay applies	Covered at 80% per admission after deductible

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Outpatient Treatment of Substance Abuse		
Outpatient Services	\$15 copay	\$30 copay No deductible applies
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	\$150 per admission copay per visit	Covered at 80% per admission after deductible
Transplant Services and Non-Facility Expenses		
Transplant Facility Expenses (Services need to be rendered at an IOE facility)	\$150 per admission copay per visit	Covered at 80% per admission after deductible
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical Equipment		
Diabetic Supplies*	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	Covered at 100% No copay applies	Covered at 80% per admission after deductible
<p>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.</p>		

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Acupuncture and Spinal Manipulation		
Acupuncture benefit Only covered in lieu of anesthesia for both tiers	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Spinal Manipulation Maximum of 30 visits per calendar year combined in Tier 1 and Tier 2	\$15 copay	\$30 copay No deductible applies
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.	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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Jaw Joint Disorder & Oral Maxillofacial Treatment		
Jaw Joint Disorder Treatment	Covered at 100% per visit No copay applies	Covered at 100% per visit No copay or deductible applies
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Prosthetic and Orthotic		
Prosthetic and Orthotic Appliances	Covered at 100% per item No copay applies unless listed under the NJ Prosthetic and Orthotic mandate. Those services are covered at 100% after a \$20 copay	Covered at 80% per item after deductible
Wigs There is a maximum benefit of \$500 every 24 months combined for Tier 1 and Tier 2	Covered at 100% per item No copay applies	Covered at 100% per item No copay or deductible applies
Important Note: The provider's reimbursement for orthotic and prosthetic appliances shall be either the Federal Medicare reimbursement schedule or the contracted rate whichever is greater.		
Chemotherapy		
Chemotherapy (Performed in a Physician's office or home care)	\$15 copay	\$30 copay No deductible applies
Chemotherapy (Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility)	\$15 copay	Covered at 80% after deductible
Infusion Therapy		
Infusion Therapy (Performed in a Physician's office or home care)	\$15 copay	\$30 copay No deductible applies

Plan Features	Network Benefit Level Tier 1	Network Benefit Level Tier 2
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	\$15 copay	Covered at 80% after deductible
Radiation Therapy		
Infusion Therapy (Performed in a Physician's office or home care)	\$15 copay	\$30 copay No deductible applies
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	\$15 copay	Covered at 80% after deductible
Autism Spectrum Disorder		
Autism Physical Therapy, Occupational Therapy and Speech Therapy	\$15 copay	\$30 copay No deductible applies
Autism – Behavioral Therapy	\$15 copay	\$30 copay No deductible applies
Autism – Applied Behavior Analysis	\$15 copay	\$30 copay No deductible applies
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	\$15 copay	\$30 copay No deductible applies
Speech Therapy only	\$15 copay	\$30 copay No deductible applies

See additional plan details in the following sections of this booklet.

Expense Provisions

The following provisions apply to your health plan.

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

Deductible Provisions

All covered expenses accumulate toward the applicable in-network deductible except for those covered expenses identified later in this Schedule of Benefits.

You and each of your covered dependents have separate calendar year deductibles. Each of you must meet your deductible separately and they cannot be combined. This Plan has individual and family calendar year Tier 2 deductibles.

Individual Deductible

This is the amount of covered expenses that you and each of your covered dependents incur each calendar year from a Tier 2 network provider for which no benefits will be paid. This individual calendar year deductible applies separately to you and each of your

covered dependents. After covered expenses reach this individual calendar year deductible; this Plan will begin to pay benefits for covered expenses that you incur from a Tier 2 network provider for the rest of the calendar year.

Family Deductible Limit

When you and each of your covered dependents incur covered expenses that apply towards the individual calendar year deductibles, these expenses will also count toward a family deductible limit.

To satisfy this family deductible limit for the rest of the calendar year, the following must happen:

The combined covered expenses that you and each of your covered dependents incur towards the individual calendar year deductibles must reach this family deductible limit in a calendar year.

When this occurs in a calendar year, the individual deductibles for you and your covered dependents will be considered to be met for the rest of the calendar year.

Copayments and Benefit Deductible Provisions

Copayment or Copay

This is a specified dollar amount of the negotiated charge required to be paid by you at the time you receive a covered service from

a network provider. It represents a portion of the applicable expense.

Per Admission Copayment

A Per Admission Copayment is an amount you are required to pay when you or a covered dependent have a stay in an inpatient facility. A copayment is a specified dollar amount of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

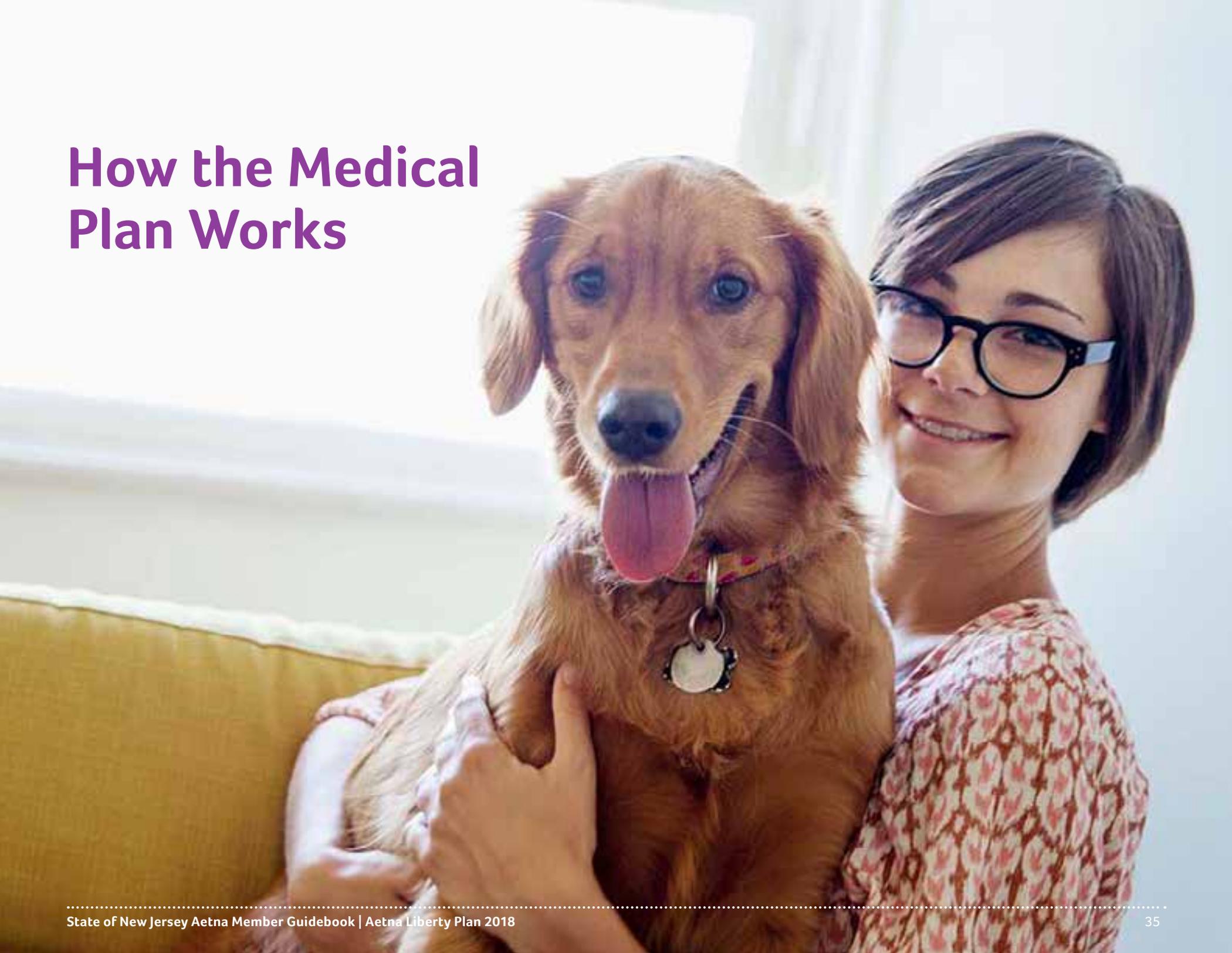
Separate copayments may apply per facility. These copayments are in addition to any other copayments applicable under this plan. They may apply to each stay or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission copayment cannot be applied to any other copayment required in your plan. Likewise, covered expenses applied to your plan's other copayments cannot be applied to meet the per admission copayment.

Coinsurance

This is a specified percentage of the negotiated charge required to be paid by you at the time you receive a covered service from a network provider. It represents a portion of the applicable expense.

How the Medical Plan Works



How the Medical Plan Works

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

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

Common Terms

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

About Your Aetna Liberty Medical Plan

This Aetna Liberty Plan provides coverage of medical expenses for the treatment of illness or injury. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Aetna Liberty Plan, you can directly access any Tier 1 or Tier 2 network hospital or other health care provider for covered services and supplies under the plan. This Plan includes network providers that are identified generically throughout the guidebook as Tier 1 network providers and Tier 2 network providers. The plan pays benefits differently when services and supplies are obtained through Tier 1 network providers and Tier 2 network providers under this plan.

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

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

Tier 1 and Tier 2 Network Providers

This Aetna Liberty Plan provides preferred benefit coverage and access to certain covered services and supplies through a network of health care providers and facilities that are unique to your plan. The network has been divided into two groups. The two groups of network providers are called Tier 1 network providers and Tier 2 network providers in this plan. Your cost sharing will be lowest when you use the Tier 1 network providers. Both groups of network providers are identified in the on-line version of the directory via DocFind® at AetnaStateNJ.com. Please be sure to look at the appropriate directory that applies to your plan, since different Aetna plans use different networks of providers. Your Plan includes different benefit levels based upon the type of network provider that you use Tier 1 or Tier 2. Some services and supplies may only be covered through certain network

providers. Refer to the Covered Benefit sections and your Schedule of Benefits to determine if any services are limited to network coverage only. Your out-of-pocket costs may vary between network and out-of-network benefits. Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

Availability of Providers

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

Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this guidebook. If Aetna or the SHBP determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting Aetna to seek a review of the determination.

Please refer to the Appeals Procedure and External Reviews sections of this guidebook.

The Primary Care Physician

To access network benefits, you are encouraged to select a Primary Care Physician (PCP) from Aetna's network of providers at the time of enrollment. You are not required to have a primary care physician, but it helpful as they coordinate your care. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf.

You may search online for the most current list of participating providers in your area by using DocFind®, Aetna's online provider directory at Aetna.com. You can choose a PCP based on geographic location, group practice, medical specialty, language spoken, or hospital affiliation. DocFind® is updated several times a week.

A PCP may be a general practitioner, family physician, internist, or pediatrician. Your PCP provides routine preventive care and will treat you for illness or injury.

A PCP coordinates your medical care, as appropriate either by providing treatment or may direct you to other network providers for other covered services and supplies.

The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization.

Specialists and Other Network Providers

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

Accessing Tier 1 and Tier 2 Providers and Benefits

- You may select a PCP or other direct access Tier 1 network provider from the DocFind® provider directory accessible at AetnaStateNJ.com. You can search Aetna's online directory, DocFind®, for names and locations of physicians, hospitals and other health care providers and facilities.
- If a service or supply you need is covered under this Plan but not available from a Tier 1 network provider in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.

- You will not have to submit medical claims for treatment received from Tier 1 network providers or Tier 2 network providers and facilities. Your Tier 1 network providers or Tier 2 network providers will take care of claim submission. Aetna will directly pay the Tier 1 network providers or Tier 2 network providers or facility less any cost sharing required by you. You will be responsible for deductibles, payment percentage and copayments, if any.
- You may be required to pay some Tier 1 network providers or Tier 2 network providers at the time of service. When you pay Tier 1 network providers or Tier 2 network providers directly, you will be responsible for completing a claim form to receive reimbursement of covered expenses from Aetna. You must submit a completed claim form and proof of payment to Aetna. Refer to the General Provisions section of this guidebook for a complete description of how to file a claim under the Aetna Liberty Plan.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe towards any deductible, copayments, or payment percentage amounts or other non-covered expenses you have incurred. You may elect

to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

Cost Sharing For Network Benefits

- Tier 1 network providers and Tier 2 network providers have agreed to accept the negotiated charge. Aetna will reimburse you for a covered expense, incurred from a Tier 1 network provider or Tier 2 network provider, up to the negotiated charge and the maximum benefits under this Plan, less any cost sharing required by you such as deductibles, copayments and payment percentage. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply.
- You must satisfy any applicable deductibles before the plan will begin to pay benefits.
- Deductibles and coinsurance are usually lower when you use designated Tier 1 network providers than when you use Tier 2 network providers.
- For certain types of services and supplies, you will be responsible for any copayments

shown in your Schedule of Benefits. The copayments will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a specialist or non-specialist. You will be subject to the PCP copayments shown on the Schedule of Benefits when you obtain covered health care services from any PCP who is a network provider.

- After you satisfy any applicable deductible, you will be responsible for any applicable coinsurance (also known as payment percentage) for covered expenses that you incur. You will be responsible for your coinsurance up to the maximum out-of-pocket limit applicable to your plan.
- Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limits for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limits. Refer to your Schedule of Benefits for information on what covered expenses do not apply to the maximum out-of-pocket limits and for the specific maximum out-of-pocket limit amounts that apply to your plan.

- The plan will pay for covered expenses, up to the benefit maximums shown in the What the Plan Covers section or the Schedule of Benefits. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers section or the Schedule of Benefits.
- You may be billed for any deductible, copayment, or payment percentage amounts, or any non-covered expenses that you incur.

Emergency and Urgent Care

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

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

In Case of a Medical Emergency

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your participating Tier 1 or Tier 2 primary care physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your PCP to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your participating Tier 1 or Tier 2 PCP as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur. Please refer to the Schedule of Benefits for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

Coverage for Emergency Medical Conditions

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

Important Note

If you visit a hospital emergency room or urgent care facility for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

Non-Participating Providers

If you seek services, supplies or care at a non-participating provider you will be responsible for the cost, unless you are seeking care at an Urgent Care Facility or Emergency Room. If your participating Tier 1 or Tier 2 provider requires you to seek care at a non-participating provider, you will have to receive authorization to do so. In order to ensure you have the proper approval to seek out of network care, your participating Tier 1 or Tier 2 physician will need to contact Aetna's Provider Services phone number on the back of your ID card.

Requirements for Coverage

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

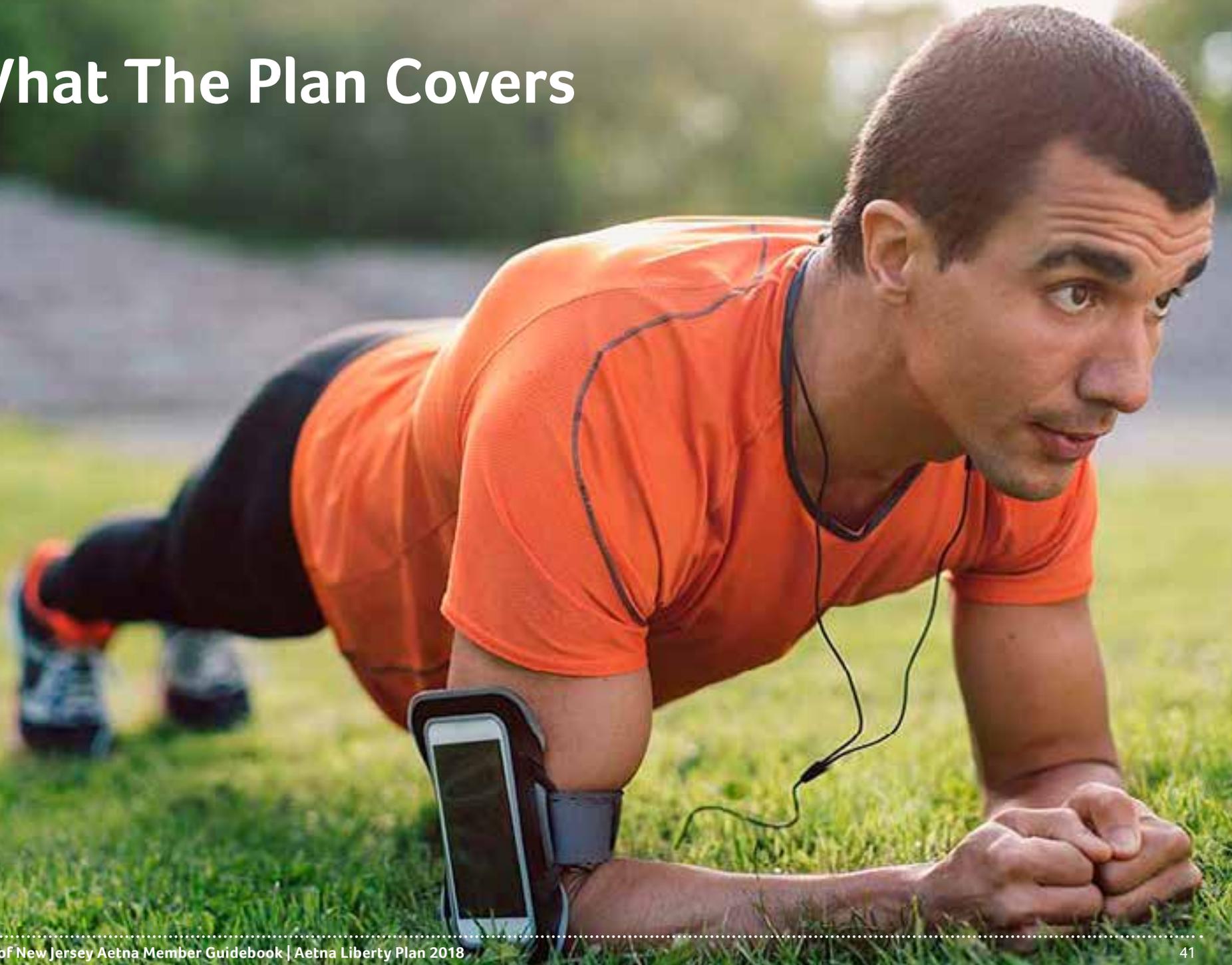
1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this guidebook;
 - Not be an excluded expense under this guidebook. Refer to the Exclusions sections of this guidebook for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this guidebook. Refer to the What the Plan Covers section and the Schedule of Benefits for information about certain expense limits; and
 - Be obtained in accordance with all the terms, policies and procedures outlined in this guidebook.
2. The service or supply must be provided while coverage is in effect. See the Summary Plan Description on the Division of Pensions and Benefits Website for more information on eligibility.
3. The service or supply must be medically necessary. To meet this requirement, the medical services or supply must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
 - In accordance with generally accepted standards of medical practice;
 - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
 - Not primarily for the convenience of the patient, physician or other health care provider;
 - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

Important Note

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

What The Plan Covers



What The Plan Covers

Aetna Liberty 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.

Routine Physical Exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services, such as:
 - Interpersonal and domestic violence;
 - Sexually transmitted diseases; and
 - Human Immune Deficiency Virus (HIV) infections.

- Screening for gestational diabetes for women.
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial hospital check-up.

Limitations:

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

- Services which are covered to any extent under any other part of this Aetna Liberty 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;
- Services and supplies furnished by an out-of-network provider.

Preventive Care Immunizations

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

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

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

Limitations:

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

Well Woman Preventive Visits

Covered expenses include charges made by your physician obstetrician, or gynecologist for:

- a routine well woman preventive exam office visit, including Pap smears. A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury; and
- routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing. Covered expenses include charges made by a

physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

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

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

Limitations:

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

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

- Services and supplies furnished by an out-of-network provider.

Routine Cancer Screenings

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

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

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

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

Limitations:

Unless specified above, not covered under this benefit are:

- Charges incurred for services which are covered to any extent under any other part of this Plan.
- Services and supplies furnished by an out-of-network provider.

Important Note

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

Screening and Counseling Services

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

Obesity and/or Healthy Diet

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

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

Misuse of Alcohol and/or Drugs

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

Use of Tobacco Products

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

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

Sexually Transmitted Infections

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

Genetic Risks for Breast and Ovarian Cancer

Covered expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

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

Limitations:

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

- Services which are covered to any extent under any other part of this plan;
- Services and supplies furnished by an out-of-network provider.

Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below. Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits

including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

Limitations:

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

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above); and
- Services and supplies furnished by out-of-network provider.

Important Note

Refer to Pregnancy Expenses and Exclusions sections of this guidebook for more information on coverage for pregnancy expenses under this plan including prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at

any time following delivery, for breast-feeding by a certified lactation support provider. Covered expenses also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk) as follows.

Breast Pump

Covered expenses include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital
- The purchase of:
 - An electric breast pump (non-hospital grade). A purchase will be covered once per pregnancy; or
 - A manual breast pump. A purchase will be covered once per pregnancy.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy.

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

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

Limitations:

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

- Services which are covered to any extent under any other part of this Plan; and
- Services and supplies furnished by an out-of-network provider.

Family Planning Services - Female Contraceptives

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

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

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

Voluntary Sterilization

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

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

Contraceptives

Covered expenses include charges made by a physician for:

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

Limitations:

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

- Services which are covered to any extent under any other part of this Plan;
- Services and supplies incurred for an abortion;
- Services which are for the treatment of an identified illness or injury;

- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA;
- Male contraceptive methods, sterilization procedures or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care;
- Services and supplies furnished by an out-of-network provider.

Family Planning Services – Other

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

- Voluntary sterilization for males;
- Voluntary termination of pregnancy.

Limitations - Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan

or any other group plans sponsored by your employer; and

- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care; and
- Services and supplies furnished by an out-of-network provider.

Important Note

Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services

- Other. For more information, see the sections on Family Planning Services
- Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this guidebook.

Vision Care Services

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

- Routine eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in a Calendar Year.

Limitations

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

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

Hearing Exam

Covered expenses include charges for an audiometric hearing exam for children thru age 15 if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
 - Is legally qualified in audiology; or
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
 - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist. The plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

All covered expenses for the hearing exam are subject to any applicable deductible, copay

and payment percentage shown in your Schedule of Benefits.

Physician Services

Physician Visits

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

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

Surgery

Covered expenses include charges made by a physician for:

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

Anesthetics

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

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by network walk-in clinics for:

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

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

- In a group setting for screening and counseling services.

Important Note

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

Hospital Expenses

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

Room and Board

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

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

Outpatient Hospital Expenses

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

Coverage for Emergency Medical Conditions

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

The emergency care benefit covers:

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

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

Important Note

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

Coverage for Urgent Conditions

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

Your coverage includes:

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

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

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses, as shown in the Schedule of Benefits.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

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

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital and
- The surgery is not normally performed in a physician's or dentist's office.

Important Note

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

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital, surgery center on the day of the procedure;
- The operating physician's services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another physician for related post-operative care and administration of

anesthesia. This does not include a local anesthetic.

Limitations

Not covered under this plan are charges made for:

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

Birth Center

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

Limitations

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

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

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense. See Pregnancy Related Expenses for information about other covered expenses related to maternity care.

Home Health Care

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

- Is given under a home health care plan;
- Is given to you in your home while you are homebound. Home health care expenses include charges for:
 - Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
 - Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
 - Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
 - Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had continued your hospital stay.
 - Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician. All of the following must be met:

- 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.
- The services are in lieu of a continued confinement in a hospital or residential treatment facility, or receiving outpatient services outside of the home.
- You are homebound because of illness or injury.
- The services provided are not primarily for comfort or convenience or custodial in nature.
- The services are intermittent or hourly in nature.
- The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, behavioral health provider or therapist is 1 visit.

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is 1 visit and
- behavioral health provider, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

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

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

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

NOTE: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed in the Short Term Rehabilitation Therapies section of the Schedule of Benefits.

Limitations

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

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

Skilled Nursing Care

Covered expenses include charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care. This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

Covered expenses also include private duty nursing provided by a R.N. or L.P.N. if the

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

Limitations

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

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

- Nursing care provided while you are an inpatient in a hospital or health care facility.
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

Skilled Nursing Facility

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

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

Limitations

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

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

Hospice Care

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

Facility Expenses

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

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

Outpatient Hospice Expenses

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

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

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

- A physician for a consultation or case management;
- A physical or occupational therapist;

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

Limitations

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

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

Other Covered Health Care Expenses

Acupuncture

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

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

Ambulance Service

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

Ground Ambulance

Covered expenses include charges for transportation:

- To the first hospital where treatment is given in a medical emergency.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.

- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance

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

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

NOTE: Air or Water Ambulance Services need to be precertified by your provider and reviewed by Aetna. Your provider can contact the Provider Services phone number on the back of your ID card.

Ambulance (Ground, Air, Water) Limitations

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

- If an ambulance service is not required by your physical condition; or
- If the type of ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional ambulance service; or
- By fixed wing air ambulance from an out-of-network provider.
- For chartered air flights, non-emergency air ambulance, invalid coach, transportation services, or other travel or lodging.
- Or for communication expenses of patients, providers, nurses or family members

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a physician, hospital or a

licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the recognized charge exceeds \$500. Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

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

Outpatient Diagnostic Lab Work and Radiological Services

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

charges must be made by a physician, hospital or licensed radiological facility or lab.

Outpatient Preoperative Testing

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

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

Limitations

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

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

Durable Medical and Surgical Equipment (DME)

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

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

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered. Replacement of purchased equipment if:

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

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

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the Exclusions section of this guidebook. 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.

Clinical Trials

Clinical Trial Therapies (Experimental or Investigational)

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

- Standard therapies have not been effective or are inappropriate;

- Aetna determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:

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

Routine Patient Costs

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

Limitations:

Not covered under this Plan are:

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

Pregnancy Related Expenses

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any

illness or injury. This includes prenatal visits, delivery and postnatal visits.

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

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

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

NOTE: Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

Maternity/Obstetrical Care for Child Dependents

In some instances, Aetna will pay bills related to the birth of a grandchild. In order for the 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 her or she obtains legal custody of the child.

Prosthetic Devices

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

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

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

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- any item listed in the Exclusions section.

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural

and binaural) for children through age 15, installed in accordance with a prescription written during a covered hearing exam.

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

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

Benefits After Termination of Coverage

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The prescription for the hearing aid was written; and
- The hearing aid was ordered.

Autism Spectrum Disorder

Covered expenses include charges made by a physician or behavioral health provider for the services and supplies for the diagnosis and treatment (including routine behavioral health services such as office visits or therapy and Applied Behavior Analysis) of Autism Spectrum Disorder when ordered by a physician, licensed psychologist, or licensed

clinical social worker, as part of a Treatment Plan; and the covered child is diagnosed with Autism Spectrum Disorder.

Applied Behavior Analysis is an educational service that is the process of applying interventions:

- That systematically change behavior; and
- That are responsible for the observable improvement in behavior.

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

Short-Term Rehabilitation Therapy Services

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

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

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

Outpatient Prescription Drugs

Preventive Contraceptives

For females who are able to reproduce, your plan covers certain drugs and devices that the U.S. Food and Drug Administration (FDA) has approved to prevent pregnancy when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. Your outpatient prescription drug plan also covers related services and supplies needed to administer covered devices. At least one form of the contraception in each of the methods is identified by the FDA is included. You can access the list of contraceptive drugs by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card. 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.

We cover over-the-counter (OTC) and generic prescription drugs and devices for each of the methods identified by the FDA at no cost share. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug for that method at no cost share.

Important Note

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

Preventive care drugs and supplements

Eligible health services include preventive care drugs and supplements (including over-the-counter drugs and supplements) as required by the Affordable Care Act (ACA) guidelines when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing.

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

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

- Physical therapy is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical

functions lost or impaired as a result of an acute illness, injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.

- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

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

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

The therapy should follow a specific treatment plan that:

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

Important Note

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

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down’s syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders.
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from illness, injury, or congenital defect;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;

- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse’s family, or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Reconstructive or Cosmetic Surgery and Supplies

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

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure.

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

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

Reconstructive Breast Surgery

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

Gender 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 or 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 Gender 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.

Specialized Care

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient

care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

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

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

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at Aetna.com or calling the number on the back of your ID card.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following

outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives). Not included under this infusion therapy benefit are charges incurred for:
 - Enteral nutrition;
 - Blood transfusions and blood products;
 - Dialysis; and
 - Insulin.

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

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

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Specialty Care Prescription Drugs

Covered expenses include specialty care prescription drugs when they are:

- Purchased by your provider, and
- Injected or infused by your provider in an outpatient setting such as:
 - A free-standing outpatient facility
 - The outpatient department of a hospital
 - A physician in his/her office
 - A home care provider in your home

Diabetic Equipment, Supplies and Education

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

- External insulin pumps;
- Injection aids for the blind;
- Blood glucose monitors without special features unless required due to blindness;

- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Important Note

All disposable supplies are to be covered under your Prescription Drug plan. Disposable supplies are not to be billed or obtained through your SHBP medical plan coverage.

Treatment of Infertility

Basic Infertility Expenses

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

Infertility Eligibility Requirements

Infertility services are covered for any abnormal function of the reproductive systems such that you are not able to:

- 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.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this guidebook as an employee, or be a covered dependent who is the employee's spouse.

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

- A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or a network infertility

specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.

- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.
- The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this guidebook.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by a network infertility specialist upon pre-authorization by Aetna, subject to all the exclusions and limitations of this guidebook:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the Schedule of Benefits section of this guidebook 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 guidebook 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 guidebook.

Eligibility for ART Benefits

To be eligible for ART benefits under this guidebook, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility

services do not result in a pregnancy in which a fetal heartbeat is detected;

- Be referred by your physician to Aetna's infertility case management unit;
- Obtain pre-authorization from Aetna's infertility case management unit for ART services by a network ART specialist.

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

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations section of the guidebook:

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

Exclusions and Limitations

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

- ART services for a female attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program;

Spinal Manipulation Treatment

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

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

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

Jaw Joint Disorder Treatment

The plan covers charges made by a physician, hospital or surgery center for the diagnosis and surgical treatment of jaw joint disorder. A jaw joint disorder is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD).

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a jaw joint disorder.

Transplant Services

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

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;

- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan. The following will be considered to be more than one Transplant Occurrence:
 - Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
 - Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
 - Re-transplant after 180 days of the first transplant;
 - Pancreas transplant following a kidney transplant;

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

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

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

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy;

bio-medicals and immunosuppressants; home health care expenses and home infusion services.

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

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

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

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

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

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered

expenses you incur from an IOE facility will be considered network care expenses.

Limitations

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

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

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or out-of-network provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated (Tier 1) by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers.

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

Inpatient Treatment

Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during

your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

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

Outpatient Treatment

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

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

Outpatient mental health treatment also includes:

- Electro-convulsive therapy (ECT); and
- Substance use disorder injectables.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers.

Substance Abuse

Please refer to the Schedule of Benefits for any substance abuse deductibles, maximums and payment limits or maximum out of pocket limits that may apply to your substance abuse benefits.

Inpatient Treatment

This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of substance abuse.
- "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

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

Partial Confinement Treatment

Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse.

Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

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

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

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

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

therapy alone cannot result in functional improvement.

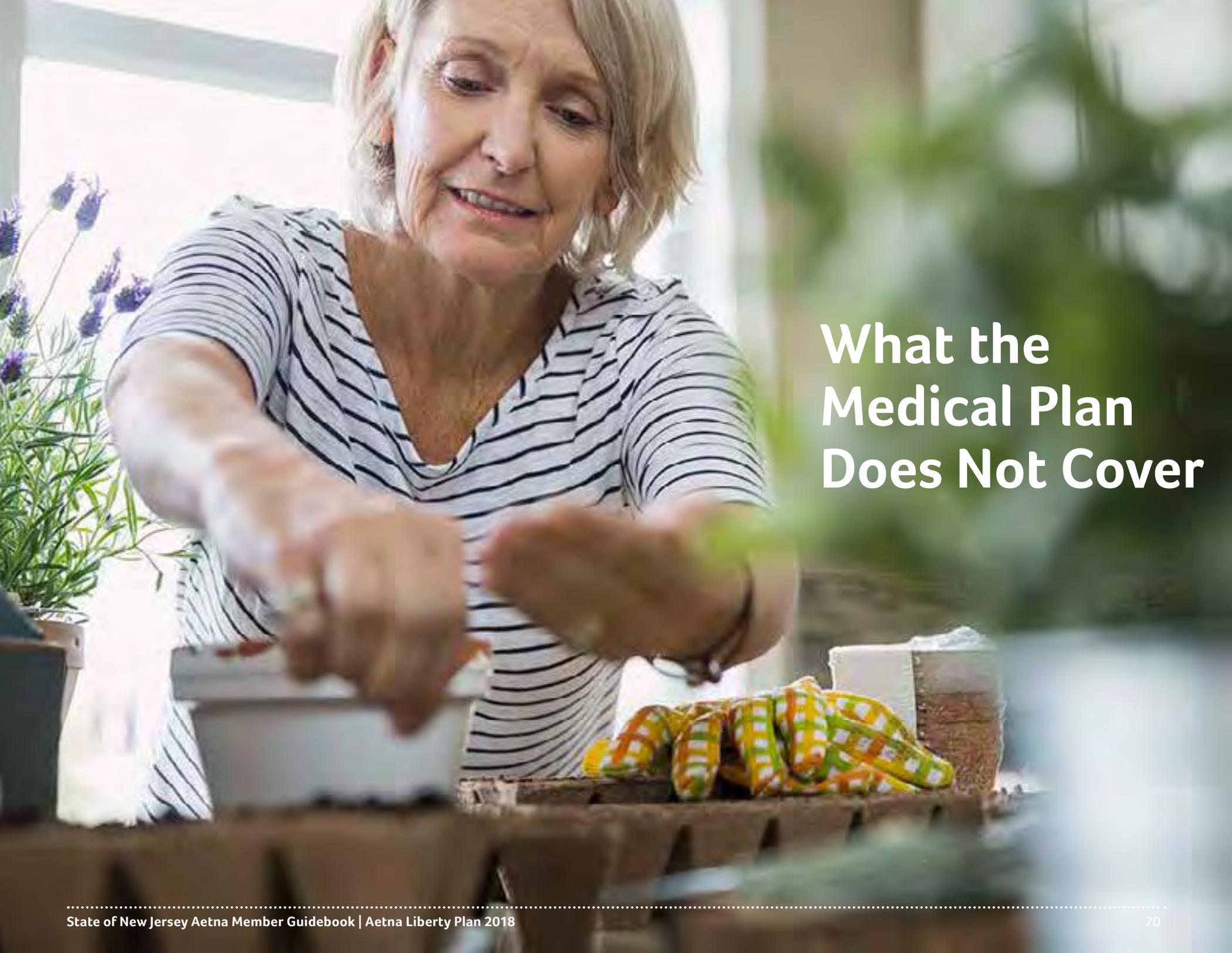
Hospital services and supplies received for a stay required because of your condition. Dental work or surgery needed to remove, repair, restore or reposition:

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

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

The treatment must be completed in the Calendar Year of the accident or in the next Calendar Year. If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:

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



What the Medical Plan Does Not Cover

What the Medical Plan Does Not Cover

What the Medical Plan Does Not Cover

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

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

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

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

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, or supplies, even if otherwise covered under this

guidebook. This also includes medical injectable medication or supplies if:

- such medical injectable medication or supplies are unavailable or illegal in the United States; or
- the purchase of such medical injectable medication or supplies outside the United States is considered illegal. Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services:

- Alcoholism or substance abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance abuse is specifically provided in the What the Medical Plan Covers Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.

- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers section of this guidebook.

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

Charges for a service or supply furnished by a Tier 1 or Tier 2 network provider in excess of the negotiated charge.

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

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

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

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

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

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;

- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

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

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

Custodial Care

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

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions,

treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

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

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

Drugs, medications and supplies – Please see your prescription drug guidebook for more information on what is covered under your prescription drug program.

Durable medical and surgical equipment including purchase, rental, replacement or repair from an out-of-network provider, except as specifically provided in the What the Plan Covers section.

Educational services:

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

Examinations:

- Any health examinations required:
 - by a third party, including examinations and treatments required to obtain or maintain employment, or which an

employer is required to provide under a labor agreement;

- by any law of a government;
- for securing insurance, school admissions or professional or other licenses;
- to travel;
- to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

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

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

Facility charges for care services or supplies provided in:

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

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

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

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

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

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility;
- Replacement parts or repairs for a hearing aid;
- Any service or supply furnished by out-of-network providers; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except otherwise provided under the What the Plan Covers section.

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

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;

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

trucks, or alterations to any vehicle or transportation device.

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

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required

for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Payment for medical services rendered to a surrogate for purposes of childbearing;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care.

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer. Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a physician's practice;
- Charges to have preferred access to a physician's services such as boutique or concierge physician practices;

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

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

Non-medically necessary services, including but not limited to, those treatments, services, medical injectable medication and supplies which are not medically necessary, as determined by Aetna, for the diagnosis and

treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.)

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

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

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

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

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

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

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

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

Services that are not covered under this guidebook. Services and supplies provided in connection with treatment or care that is not covered under the plan. Services and supplies provided by an out-of- network provider.

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

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

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

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

use of performance- enhancing drugs or preparations.

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

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

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;

- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

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

the NJWELL Program via ActiveHealth Management. Please locate more information about the NJWELL Program and current information at AetnaStateNJ.com.

Transplant-The transplant coverage does not include charges for:

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

Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as described in the What the Plan Covers section.

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

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

- Special supplies such as non-prescription sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your stay in a hospital or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;

- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.
- Lenses of any type except initial lens replacement for loss of natural lens after cataract surgery

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

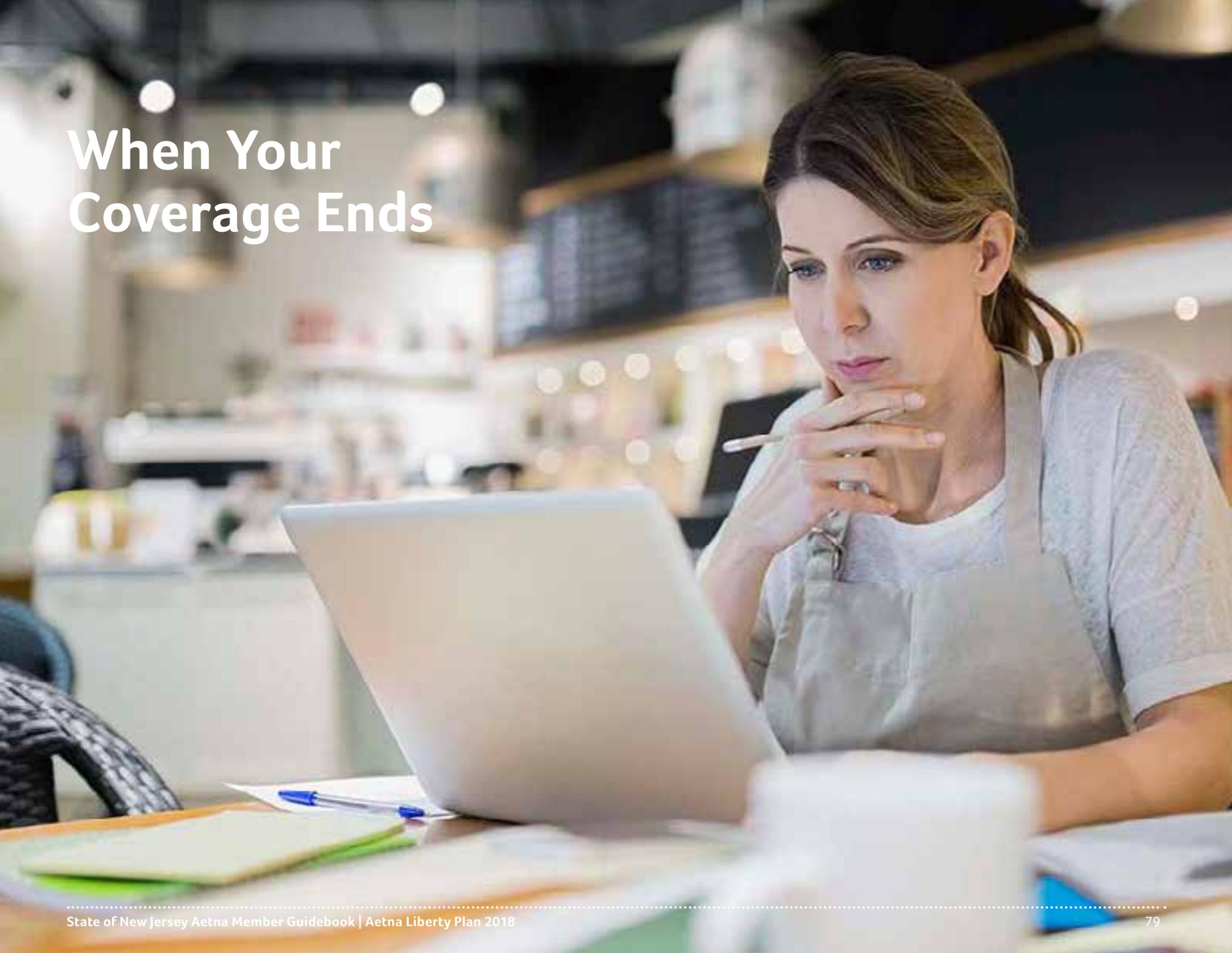
- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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

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

When Your Coverage Ends



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 Aetna health benefits coverage will end if:

- The Aetna health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit; or

- Your employer notifies the New Jersey Division of Pensions & Benefits that your employment is ended. In turn, the New Jersey Division of Pensions and Benefits will notify Aetna.

It is your employer's responsibility to let the New Jersey Division of Pensions & Benefits know when your employment ends.

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:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;

- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees. (This does not apply if you use up your overall lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership.

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

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 & 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 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 (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.)

Additional COBRA Information **Continuing Coverage through COBRA**

COBRA Continuation of Coverage

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of contributions.

Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

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

You or your dependents will need to:

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

Who Qualifies for COBRA

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

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

Disability May Increase Maximum Continuation to 29 Months

If You or Your Covered Dependents Are Disabled

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

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

If There Are Multiple Qualifying Events

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

Determining Your Contributions For Continuation Coverage

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

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

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

A close-up photograph of a person's hands holding a white binder. The binder has several colored tabs on the left side, numbered 5, 6, 7, 8, 9, 2, and 6. The person is wearing a floral patterned shirt and a gold ring on their finger. The background is blurred, showing another person in a white shirt.

Coordination of Benefits

Coordination of Benefits

Coordination of Benefits – What happens when there is more than one health plan

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This Plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in

part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.
- If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.

- The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
- If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or recognized charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be

the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;

- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
 - Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
 - Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:
 - The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married or living together whether or not married;
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
 - If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;

- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

- Active Employee or Retired or Laid off Employee. The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
- Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee,

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

- Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber longer is primary.
- If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, this plan will not pay more than it would have paid had it been primary.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the

total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made”

includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

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

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

You are eligible for Medicare if you are:

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

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

circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances. How Coordination With Medicare Works

When the Plan is Primary

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

When Medicare is Primary

Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration.

Aetna will calculate the benefits the plan would pay in the absence of Medicare:

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

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

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

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

Right to Receive and Release Required Information

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

General Provisions

Precertification

Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning) and to register you for specialized programs or case management when appropriate.

Precertification starts with a telephone call to Member Services:

- By using a Tier 1 or Tier 2 provider, your provider will make this call for you.

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This guidebook applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.

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

- The plan may be changed or discontinued with respect to your coverage.

Financial Sanctions Exclusions

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

Assignments

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

Misstatements

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

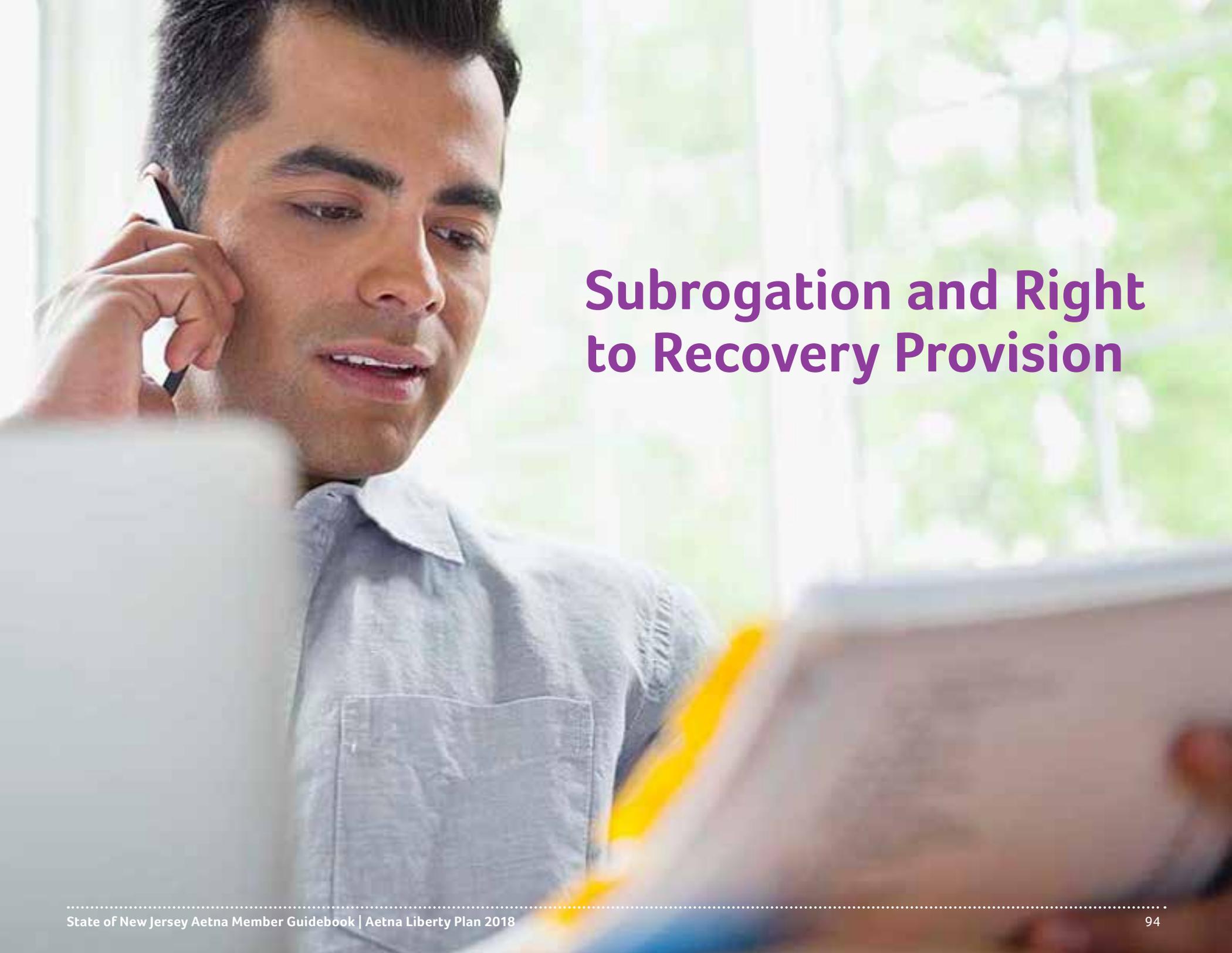
Fraudulent misstatements in connection with any claim or application for coverage may result in termination of all coverage under this plan.

Rescission of Coverage

The New Jersey Division of Pensions & Benefits may rescind your coverage with Aetna if you, or the person seeking coverage on your behalf:

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

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



Subrogation and Right to Recovery Provision

Subrogation and Right to Recovery Provision

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

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

Automobile Related Injuries

The SHBP Plan will provide secondary coverage to Personal Injury Protection (PIP) unless you choose your Plan as your primary insurer on your automobile policy. In addition, if your automobile policy contains provisions that make PIP secondary or as excess coverage to your health plan, then the Plan will automatically be primary to your PIP policy. If you elect your Plan as primary, this election may affect each of your family members differently.

When the SHBP Plan is primary to your PIP policy, benefits are paid in accordance with the terms, conditions, and limits set forth by the Plan you have chosen. For example, if you are enrolled in an HMO you would need referrals from your Primary Care Physician, precertifications, preauthorizations, etc., just as you would for any other treatment to be covered. Your PIP policy would be a secondary payer to whom you would submit any bills unpaid by your Plan. Any portions of unpaid bills would be eligible for payment under the terms and conditions of your PIP policy.

If your Plan is secondary to the PIP policy, the actual benefits payable will be the lesser of:

- The remaining uncovered allowable expenses after the PIP policy has provided coverage. The expenses will be subject to

medical appropriateness and any other provisions of your Plan, after application of any deductibles and coinsurance; or

- The actual benefits that would have been payable had your Plan been primary to your PIP policy. If you are enrolled in several health plans regardless of whether you have selected PIP as your primary or secondary coverage, the plans will coordinate benefits as dictated by each plan's coordination of benefits terms and conditions. You should consult the coordination of benefits provisions in your various plans' guidebooks and your PIP policy to assist you in making this decision.

Important Note

There is no coordination of benefits for prescription drug expenses.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied in the State's permitted for subrogation. Please note that coordination with your auto coverage may be impacted by certain special plan provisions for the SHBP/SEHBP.

Subrogation

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

Reimbursement

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

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a

constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

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

Assignment

In order to secure the plan's recovery rights, you agree to assign to the plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows

the plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

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

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated (Tier 1) as pain and

suffering, non-economic damages, and/or general damages only. The plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the plan's efforts to recover benefits paid. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you

receive may result in the denial of any future benefit payments or claim until the plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health plan's subrogation and reimbursement interest.

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

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

Interpretation

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

Jurisdiction

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

Work-Related Injury or Disease

Work-related injuries or disease are not covered under the SHBP. This includes the following:

- Injuries arising out of or in the course of work for wage or profit, whether or not you are covered by a Workers' Compensation policy.

- Disease caused by reason of its relation to Workers' Compensation law, occupational disease laws, or similar laws.

Work-related tests, examinations, or immunizations of any kind required by your work.

Important Note

If you collect for the same injury or disease from both Workers' Compensation and SHBP, you may be subject to prosecution for insurance fraud.

Workers' Compensation

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

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

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

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

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

Recovery of Overpayments

Health Coverage

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

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

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

Reporting of Claims

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

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

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

Payment of Benefits

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

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

When a PCP provides care for you or a covered dependent, or care is provided by a Tier 1 or Tier 2 network provider (network services or supplies), the network provider will take care of filing claims. Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made. Very important are:

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

Contacting Aetna

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

**Aetna Life Insurance
Company 151
Farmington Avenue
Hartford, CT 06156**

You may also use Aetna's toll free Member Services phone number on your ID card or visit Aetna's Navigator web site at AetnaStateNJ.com.

Special Programs and Resources



Special Programs and Resources

Special Programs and Resources

Discount Arrangements

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

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

Visit Aetna Navigator at AetnaStateNJ.com to find the latest discount arrangements available to you.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your physician or other service providers, the Division of Pensions & Benefits may, from time to time, offer financial incentives. Aetna and the Division of Pensions and Benefits has the right to determine the amount of financial incentive and to limit the covered persons to whom these arrangements are available. For more information on their wellness programs please visit AetnaStateNJ.com.

Health and Disease Management Programs

Beginning Right® Maternity Program

This program helps pregnant women stay well and deliver healthier babies. It provides:

- Information on prenatal care, labor and delivery, newborn care and more;
- A pregnancy risk survey to see if you're at risk for certain complications;
- Extra support from obstetrically trained nurse case managers if you're at risk;
- A preterm labor prevention program that offers educational information on the risks of preterm

- labor and delivery, telephone outreach and follow-up; and
- Smoke-Free Moms-to-Be®, a nicotine-free smoking cessation program designed specifically for pregnant women.

How Do I Get Information About This Program?

As soon as Aetna is notified of your pregnancy, an Aetna nurse calls you to get things started. Or you can call and enroll yourself at: **1-800-CRADLE-1 (272-3531)**.

When you participate in this program, all your care is coordinated by your Ob/Gyn and Aetna case managers.

ActiveHealth Disease Management Program

Not everyone can be perfectly healthy. But, even with an ongoing health condition, we can provide support to help you achieve your best level of personal health. Our support programs can help you and your family members:

- Understand your condition
- Answer questions about treatment plans, medications and care management
- Better manage your condition
- Make lifestyle changes that can help, or sometimes reverse your condition

- Identify and manage potential risks for other conditions

The program provides support for more than 35 conditions, including bone and joint, kidney as well as cancer and diabetes.

How the program works – As an example let’s say you have diabetes. You may contact ActiveHealth Management to join the program, or we may contact you to see if you want help managing your health concerns. Our nurses can then teach you about your condition and send you information as well as provide you with resources to keep you on track. They will also help to review your treatment plan and the medications that your doctor recommends. We have a 24-hour line for you to contact with support.

After you speak with a nurse, you will receive follow-up communication, which will list the points discussed and the steps you should take before your next discussion with a nurse. Our support team can help you to learn how to protect yourself against future health problems. Visit AetnaStateNJ.com for additional information under “Wellness”.

Advanced Illness Options

The Aetna Compassionate CareSM program offers service and support when you are facing difficult decisions about an advanced

illness. The program’s nurse case managers work with doctors to:

- Arrange for care and manage benefits;
- Find resources for the patient and family members; and
- Help family members and other caregivers manage the patient’s pain and symptoms.

Call Aetna Member Services to talk with a nurse case manager about the Aetna Compassionate Care program. Online support is also available at aetnacompassionatecare.com.

Transplant Support: The National Medical Excellence Program[®]

The National Medical Excellence Program (NME) helps you receive care from nationally recognized doctors and facilities experienced in performing organ transplants, bone marrow transplants and other complicated procedures. For patients who take part in this program, the Plan pays benefits for covered medical expenses incurred for the NME procedures and treatment types listed in this section.

The program includes:

- National Transplant Program – coordinates care and provides access to covered treatment through the Institutes of Excellence[™] Transplant Network.

- National Special Case Program – assists members with rare or complex conditions requiring specialized treatment in evaluating treatment options and obtaining appropriate care.
- Out-of-Country Care Program – supports members who need emergency inpatient medical care while temporarily traveling outside the United States.

These services must be preauthorized by Aetna.

Travel and Lodging

When NME arranges for treatment at a facility more than 100 miles from your home, the Plan provides travel and lodging allowances for you and one companion, including round trip (air, train or bus) transportation costs (coach class only), or mileage, parking and tolls if traveling by auto.

Benefits for travel and lodging expenses are subject to a maximum of \$10,000 per transplant or procedure. Lodging expenses are subject to a \$50 per night maximum per person, or \$100 per night total.

The Plan will pay for travel and lodging expenses beginning on the day you become a participant in the National Medical Excellence Program. Coverage ends on the earliest of:

- One year after the day a covered procedure was performed; or
- On the date you cease to receive any services from the program provider in connection with the covered procedure; or
- On the date your coverage terminates under the Plan.

The Plan covers only those services, supplies and treatments considered necessary for your medical condition. The Plan does not cover treatment considered experimental or investigational (as determined by Aetna) except in the case of an approved clinical trial.

Important Note

Travel and lodging expenses must be approved in advance by Aetna. The Plan does not cover expenses that are not approved.

Inpatient and partial-hospitalization care must be precertified by Aetna. Refer to Precertification for more details about precertification procedures.

Aetna Behavioral Health

Anyone — any age, gender, income, race or religion — can develop a behavioral health condition, like depression. These conditions are linked to brain functioning.

And they can affect how someone thinks, feels and acts. Sometimes, a condition is mild. Other times, it is more serious and long lasting. Either way, recovery is always possible. But first, a condition must be diagnosed and treated.

If you are coping with a behavioral health condition, there is good news. Your medical plan includes behavioral health benefits. That means we're here with the help you need to work toward recovery. So that you can get back to being your best.

Coverage for many conditions

Your benefits provide access to treatment for many types of conditions:

Anxiety

Anxiety is a feeling of uneasiness or fear. It affects some people from time to time. For others, it can last for years and affect their work and home life. But treatment can help. Many people respond well to therapy, medication or a combination of both.

Depression

Depression is more than feeling sad. It is a mood disorder. And it can affect your thoughts, mood, health and behavior. Depression is treatable. Usually, a combination of therapy and medicine is effective.

When not treated, it can become a chronic condition.

Substance abuse

You might think of prescription or illegal drugs when you hear about substance abuse. But drinking is the most common substance abuse problem people face.

As with abusing prescription or illegal drugs, drinking can lead to:

- Impaired judgment and embarrassing or dangerous situations
- Problems at work
- Relationship issues
- Trouble with authorities and the police
- Car accidents and DUIs

Help is available if you feel you have a problem. First, look for community help and support groups in your area. Often having a support network can really help people change their habits. Or talk to your doctor, who can connect you with the support you need.

Eating disorders

A positive body image and healthy relationship with food support good health. But for some people, an obsession with weight or food can take over. An eating disorder like this can affect physical well-being and self-esteem. It can even become life threatening. If you are struggling with an eating disorder, treatment is available. It can start you on your way to

lifelong healthy eating habits. And it can help you see yourself in a whole new way.

Contact our Behavioral Health Program at **1-800-424-4660**.

Aetna Navigator®

Aetna Navigator® is our secure member website that's available, 24/7. All of your health benefits, health insurance plan information and cost-savings tools are in one place. Once you sign up, you can:

- Compare cost estimates for health care services based on their health plan
- Compare hospital facility rates and quality and learn average medical care costs for their area
- View deductible and plan limits
- View summary of coverage and benefits
- Save on health-related products and services
- Store and share their personal health history
- Get instant access to claims and Explanation of Benefits statements
- Track their health goals
- Research prescription drugs and order medications

- Find forms and view/print ID cards
- Ask Ann, Aetna's Virtual Assistant

Register by visiting AetnaStateNJ.com and then choose the Aetna Navigator® icon to login.

Aetna Mobile

That's why it's great to know you can use your cell phone with web access to view your health plan information — whenever you want, wherever you are.

The Aetna Mobile app is available for Android™ and iPhone® mobile devices. Use a different smartphone or mobile device? Instead of loading an app, just visit Aetna.com

and use the mobile web version of the site.

Two ways to download your FREE Aetna Mobile app:

- Text Apps to 23862 to download now.*
- Scan the code with your mobile device.

To learn more, visit us at Aetna.com/mobile.

*Standard text messaging rates may apply.

Aetna DocFind® – Online Provider Directory

Before deciding on your health coverage, you want to know which doctors and hospitals you can visit. Our online directory lets you search for them. And find out more about them, too.

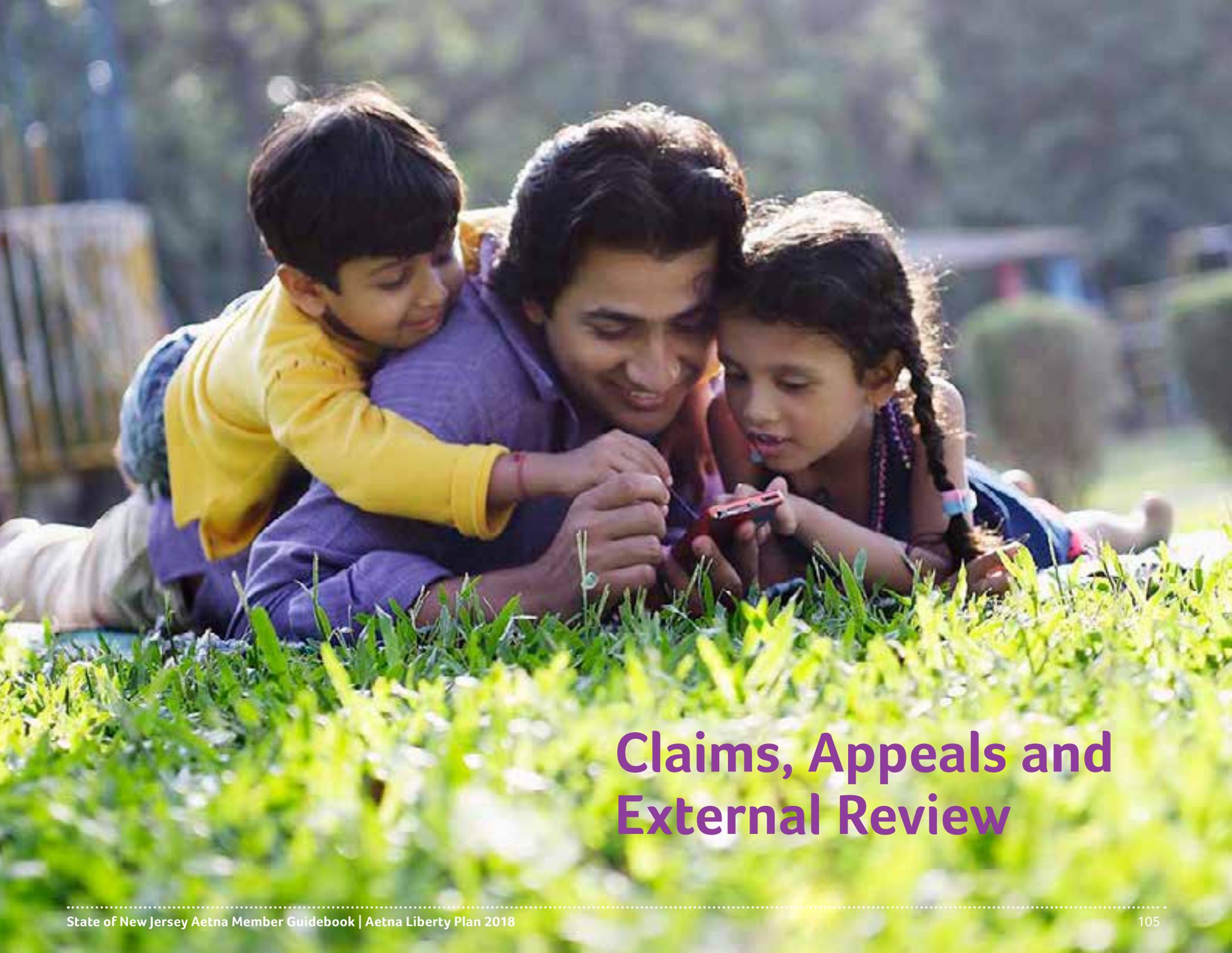
Use it to:

Save money. Your costs are usually lower when you choose doctors, hospitals, walk-in clinics, labs and other health providers in our network. So we point them out to you.

See the latest. There's lots of helpful information on network doctors and facilities. And it's updated daily.

Get your results. Once you sign up for your member website, our directory "recognizes" your health benefits and insurance plan. That means search results are right for you.

Access your specific SHBP DocFind® by visiting AetnaStateNJ.com and then choose the Aetna DocFind® icon to login.



Claims, Appeals and External Review

Claims, Appeals and External Review

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.

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 guidebook, 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.

Health Claims – Voluntary Appeals

External Review

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

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

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

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

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

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

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

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if

the claim decision involves medical judgment and the following are satisfied:

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

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

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

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

Preliminary Review

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

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

Referral to ERO

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

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

- Your medical records;
- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- 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;
- 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;
- 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
- 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.

Glossary

Glossary

A

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

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

Average Wholesale Price (AWP) The current average wholesale price of a prescription drug listed in the Facts and Comparisons weekly price updates (or any other similar publication designated (Tier 1) by Aetna) on the day that a pharmacy claim is submitted for adjudication.

B

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

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

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.

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

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

Brand-Name Prescription Drug A prescription drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated (Tier 1) by Aetna or an affiliate.

C

Copay or Copayment The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various copayments, and these copayment amounts or percentages are specified in the Schedule of Benefits.

Cosmetic Services or supplies that alter, improve or enhance appearance.

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

Creditable Coverage A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);

- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-CHIP).

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);

- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

D

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

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

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

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

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

as determined by a physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory A listing of all network providers serving the class of employees to which you belong. The contractholder will give you a copy of this directory. Network provider information is also available through Aetna's online provider directory, DocFind®.

Division of Pensions & Benefits (Health Benefits Bureau) The administrator with Aetna of the group medical plan you are participating in.

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

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

E

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

Emergency Medical Condition A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of

such a nature that failure to get immediate medical care could result in:

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

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

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
- Approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
- It is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or

research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or

- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
 - drug;
 - device;
 - procedure; or
 - treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental or investigational, or for research purposes.

H

Homebound This means that you are confined to your place of residence:

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

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

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

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

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

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

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

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

- Establishes policies about how hospice care is provided.
- Assesses the patient’s medical and social needs.
- Develops a hospice care program to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

Hospice Care Program This is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and

- Includes an assessment of the person’s medical and social needs; and a description of the care to be given to meet those needs.

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

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

Hospital An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;

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

Hospitalization A continuous confinement as an inpatient in a hospital for which a room and board charge is made.



Illness A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

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

Below are the eligibility requirements as per the State of New Jersey Infertility Mandate.

- 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.

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

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

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

J

Jaw Joint Disorder This is:

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

L

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

M

Mail Order Pharmacy An establishment where prescription drugs are legally given out by mail or other carrier.

Maintenance Care Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit Your plan has a maximum out-of-pocket limit. Your deductibles, payment percentage, copays and other eligible out-of-pocket expense apply to the maximum out-of-pocket limit. Once you satisfy the maximum amount the plan will pay 100% of covered expenses that apply toward the limit for the rest of the Calendar Year.

Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would give to a patient for the purpose of:

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

The provision of the service, supply or must be:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not mostly for the convenience of the patient, physician, other health care or dental provider; and

- And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

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

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

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

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

Morbid Obesity This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge The maximum charge a network provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

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

Network Provider (Tier 1 or Tier 2) A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Aetna's consent, included in the directory as a network provider for:

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

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

- Furnished by a designated (Tier 1) network provider and non-designated (Tier 2) network provider; or
- Furnished or arranged by your PCP.

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

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

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

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

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

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

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

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

Non-Specialist A physician who is not a specialist.

Non-Urgent Admission An inpatient admission that is not an emergency admission or an urgent admission.

O

Occupational Injury or Occupational Illness

An injury or illness that:

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

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

- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.
- Of the bite; or
- Of the jaws or jaw joint relationship; whether or not for the purpose of relieving pain.

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

P

Partial Confinement Treatment A plan of medical, psychiatric, nursing, counseling, and/or therapeutic services to treat mental disorders and substance abuse. The plan must meet these tests:

- It is carried out in a hospital; psychiatric hospital or residential treatment facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.

Payment Percentage (Coinsurance)

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

Physician A duly licensed member of a medical profession who:

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

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

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

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

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

- Is selected by a person from the list of primary care physicians in the directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and

Psychiatric Hospital This is an institution that meets all of the following requirements.

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

The plan must be supervised by a psychiatric physician.

- Makes charges.
- Meets licensing standards.

Psychiatric Physician This is a physician who:

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

R

Rehabilitation Facility A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

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

Residential Treatment Facility (Mental Disorders) This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;

- Provides treatment services that are managed by a behavioral health provider who functions under the direction/ supervision of a medical director; and
- 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.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential Treatment Facility (Substance Abuse) This is an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities

(CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;

- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient’s illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/ supervision of a medical director; and
- 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.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

R.N. A registered nurse.

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

S

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

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

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

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from
 - illness or injury:
 - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.

- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of Hospitals of the American Osteopathic Association; or

- The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated (Tier 1) for skilled or rehabilitation services.

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

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

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

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

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

Substance Abuse This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric

Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

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

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - Physicians who practice surgery in an area hospital; and

- Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:

- A physician trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.

- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care) Terminally ill means a medical prognosis of 12 months or less to live.

U

Urgent Admission A hospital admission by a physician due to:

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

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

Urgent Care Provider This is:

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

- Has contracted with Aetna to provide urgent care; and
- Is, with Aetna's consent, included in the directory as a network urgent care provider. It is not the emergency room or outpatient department of a hospital.

Urgent Condition This means a sudden illness; injury; or condition; that:

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

W

Walk-in Clinic Walk-in Clinics are free-standing health care facilities. They are an alternative to a physician's office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither:

- An emergency room; nor
- The outpatient department of a hospital; shall be considered a Walk-in Clinic.

Important Health Care Reform Notices

Important Health Care Reform Notices

Important Health Care Reform Notices

Choice of Provider

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

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

If your Aetna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider

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

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician

assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- all stages of reconstruction of the breast on which a mastectomy has been performed;
- surgery and reconstruction of the other breast to produce 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 provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, [cms.gov/home/regsguidance.asp](https://www.cms.gov/home/regsguidance.asp), and this U.S. Department of Labor website, [dol.gov/ebsa/consumer_info_health.html](https://www.dol.gov/ebsa/consumer_info_health.html).

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

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

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

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

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

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

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for

such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

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

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

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

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.

Kapau 'oku fiema'u hā tokoni 'i he lea
faka-Tonga telefoni 1-800-370-4526 'o 'ikai hā
tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk)
kopwe kékkéeri 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)

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

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

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

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

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 the New Jersey Division of Pensions & Benefits. The information herein is believed accurate as of the date of publication and is subject to change without notice.

AetnaStateNJ.com

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