

Summary Plan Description Aetna Choice POS II

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Important Notice

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

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

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

This book replaces and supersedes all books describing coverage for the medical benefits plan described in this Book that you may previously have received. The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Employer..... **Wayne County**
Contract Number..... **838928**
Effective Date..... **January 1, 2013**
Book Number..... **1**

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply. It is your responsibility to notify us if you or your dependents are no longer eligible for coverage under any of the Plans. Employees are responsible to reimburse the Plans for any administrative or claim expenses incurred by the Plan for coverage provided for ineligible members.

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

Refer to the “What the Plan Covers” section of the Book for more information about your coverage.

Treatment Outcomes of Covered Services

Wayne County and Aetna are not providers of health care services and therefore are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Aetna or its affiliates.

When Your Coverage Begins

Who Can Be Covered, How and When to Enroll, When Your Coverage Begins

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

Who Can Be Covered

Elected Officials/Employees

To be covered by this plan, the following requirements must be met:

- You must be *actively employed* (defined as actively working or using sick, vacation and/or comp time); and
- You will need to be in an “eligible class,” as defined below; and
- You will need to meet the “eligibility date criteria” described below.
- You will need to complete an application form, turn in and be accepted for coverage.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are an Elected Official or regular full-time employee, as defined by your employer (for purposes of this Summary Plan Description, full-time is defined as being scheduled to work at least 30 hours per week).
- You enroll for and are accepted in the benefit plan

Determining When You Become Eligible

You become eligible for the plan on your eligibility date, which is determined as follows:

On the Effective Date of the Plan

If you are in an eligible class on the effective date of this plan, your coverage eligibility date is the effective date of the plan.

After the Effective Date of the Plan

If you are hired or enter an eligible class after the effective date of this plan, your eligibility date is as follows:

- The first of the month that occurs 1 calendar month *after* the month in which you are hired (this is considered your Administrative Period).
- Example: If your hire date is between January 1 and January 31, 2017, you will start on the Health Plan on March 1, 2017.
- This is effective for all employees hired on or after January 1, 2017.

Obtaining Coverage for Dependents

Qualified dependents can be covered under this Plan. You may enroll the following dependents:

- Your spouse.
- Your children.

Updated 1/1/18

Aetna will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Spouses

To be eligible, an eligible spouse must meet the following definition:

- The marriage is recognized by the State of Ohio as being a legal marriage; and
- You are married and living together as a married couple; or
- You are married and living apart, but not legally separated under a decree of divorce, separate maintenance or legal separation document; or
- You are separated under an interlocutory (not final) decree of divorce.

Coverage for Eligible Children

To be eligible, an eligible child must be under 26 years of age and qualify as identified below under “An Eligible Child”.

An Eligible Child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you (our employee) are responsible under court order.

Coverage for Stepchildren

Coverage for stepchildren is only available if a child support order has been issued that requires the employee’s spouse (the child’s parent) to provide health insurance coverage for the child and the spouse is enrolled in our plan.

Coverage for a handicapped child may be continued past the age limits shown above. See “Handicapped Dependent Children” for more information.

Important Reminder: Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Please note that you will need to provide proof of your dependents’ eligibility (such as a Marriage or Birth Certificate and any court orders) when you originally enroll your dependent and whenever we conduct eligibility audits.

How and When to Enroll

Initial Enrollment in the Plan

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by Aetna and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents. You will also need to agree to make required contributions for any contributory coverage. Your employer will determine the amount of your plan contributions, which you will need to agree to before you can enroll. Your employer will advise you of the required amount of your contributions and will deduct your contributions from your pay. Remember plan contributions are subject to change.

You will need to enroll within 31 days of your eligibility date. Otherwise, you may be considered a Late Enrollee. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify under a Special Enrollment Period, as described below.

If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide you with information on when and how you can enroll.

Late Enrollment

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

You must return your completed enrollment form before the end of the next annual enrollment period as described below.

However, you and your eligible dependents may not be considered Late Enrollees if you qualify for one of the circumstances described in the “Special Enrollment Periods” section below.

Annual Enrollment/Open Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. Annual enrollment typically occurs from mid-October to mid-November. The choices you make during this annual enrollment period will become effective on January 1 of the following year.

If you do not enroll yourself or a dependent for coverage when you first become eligible, but wish to do so later, you will need to do so during the next annual enrollment period, unless you qualify under one of the Special Enrollment Periods, as described below.

Special Enrollment Periods

You will not be considered a Late Enrollee if you qualify under a Special Enrollment Period as defined below. If one of these situations applies, you may enroll before the next annual enrollment period.

Updated 1/1/18

Loss of Other Health Care Coverage

You or your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
 - You or your dependents were covered under other creditable coverage; and
 - You refused coverage and stated, in writing, at the time you refused coverage that the reason was that you or your dependents had other creditable coverage; and
- You or your dependents are no longer eligible for other creditable coverage because of one of the following:
 - The end of your employment;
 - A reduction in your hours of employment (for example, moving from a full-time to part-time position);
 - The ending of the other plan's coverage;
 - Death;
 - Divorce or legal separation;
 - Employer contributions toward that coverage have ended;
 - COBRA coverage ends;
 - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
 - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
 - With respect to coverage under Medicaid or an State Children's Health Insurance Program (S-CHIP) Plan, you or your dependents no longer qualify for such coverage; or
- You or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid or an S-CHIP Plan.
- You will need to enroll yourself or a dependent for coverage within:
 - 31 days of when other creditable coverage ends;
 - within 60 days of when coverage under Medicaid or an S-CHIP Plan ends; or
 - within 60 days of the date you or your dependents become eligible for Medicaid or S-CHIP premium assistance.

Evidence of termination of creditable coverage must be provided to your employer or the party it designates. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

New Dependents

You and your dependents may qualify for a Special Enrollment Period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and your dependent within 31 days of acquiring the dependent.

Your spouse or child who meets the definition of a dependent under the plan may qualify for a Special Enrollment Period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 31 days of a court order requiring you to provide coverage.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to your employer within 31 days of the change. If you do not return the form within 31 days of the change, you will need to make the changes during the next annual enrollment period.

If You Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement;
- Proof of placement will need to be presented to your employer prior to the dependent enrollment;
- Any coverage limitations for a preexisting condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

When You Receive a Medical Child Support Order

A Medical Child Support Order is an order issued by a court or an administrative agency authorized to issue child support orders that provides for the medical support of a child.

In addition, a properly completed National Medical Support Notice (NMSN) that has been issued by a state child support enforcement agency must be treated as an MCSO.

This plan will provide coverage for a child who is covered under an MCSO, if;

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the issuance of the medical child support order; or
- A state child support enforcement agency issues a National Medical Support Notice (NMSN) that the group health plan determines to be qualified.

Coverage for the dependent will become effective on the date of issuance of the medical child support order if received within 31 days of issuance, or as required by the NMSN. Any coverage limitations for a preexisting condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under an MCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

Please note that you and your spouse have to enroll in the plan in order to enroll your step child under an MCSO.

When Your Coverage Begins under Special Enrollment Periods

Your Effective Date of Coverage

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

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

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

Important Notice: You must pay the required contribution in full or coverage will not be effective.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

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

How Your Medical Plan Works

Common Terms, Assessing Providers, Pre-Certification

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

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

Important Notices:

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

Common Terms

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

About Your Aetna Choice POS II Medical Plan

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

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

This plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This plan is designed to lower your out-of-pocket costs when you use network

providers for covered expenses. Your deductibles, copayments, and payment percentage will generally be lower when you use participating network providers and facilities.

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

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

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

Availability of Providers

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

Ongoing Reviews

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

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

How Your Aetna Choice POS II Medical Plan Works

The Primary Care Physician

To access network benefits, you are encouraged to select a Primary Care Physician (PCP) from Aetna’s network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf. By choosing a PCP you will have one medical professional helping you navigate all of your healthcare needs. 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. Selection of a PCP is not required by this Plan, but this option is available to you.

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

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 Book. Refer to the Aetna provider directory to locate network specialists, providers and hospitals in your area. Refer to the "Schedule of Benefits" section for benefit limitations and out-of-pocket costs applicable to your plan.

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

Updated 1/1/19

Accessing Network Providers and Benefits

- You may select a network provider from the network provider directory or by logging on to Aetna's website at www.aetna.com. You can search Aetna's online directory, *Find Care*, for names and locations of physicians and other health care providers and facilities..
- If a service you need is covered under the plan but not available from a network provider or hospital in your area, please contact Member Services by email or at the toll-free number on your ID card for assistance.
- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification with Aetna to verify coverage for these services. You do not need to pre-certify services provided by a network provider. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a network provider's failure to pre-certify services. Refer to the "Understanding Precertification" section for more information on the precertification process and what to do if your request for precertification is denied.
- You will not have to submit medical claims for treatment received from network health care professionals and facilities. Your network provider will take care of claim submission. Aetna will directly pay the network provider or facility less any cost sharing required by you. You will be responsible for deductibles, payment percentage and copayments, if any.

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

Cost Sharing for Network Benefits

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

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

- For certain types of services and supplies, you will be responsible for any copayments shown in the “Schedule of Benefits”.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur. Your payment percentage is based on the negotiated charge. You will not have to pay any balance bills above the negotiated charge for that covered service or supply. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.
- Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to the “Schedule of Benefits” section for information on what expenses do not apply. Refer to your “Schedule of Benefits” for the specific maximum out-of-pocket limit amounts that apply to your plan.
- The plan will pay for covered expenses, up to the maximums shown in the “What the Plan Covers” or “Schedule of Benefits” sections. You are responsible for any expenses incurred over the maximum limits outlined in the “What the Plan Covers” or “Schedule of Benefits”

Updated 1/1/19

sections.

- You may be billed for any deductible, copayment, or payment percentage amounts, or any non-covered expenses that you incur.
- It is your responsibility to know if your provider is in, or out, of Network. Your doctor is not responsible to only refer you to Network providers, so please verify with each provider if they are in, or out, of Network before you have your appointment

Cost Sharing for Out-of-Network Benefits

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

- You will need to satisfy any applicable deductibles before the plan will begin to pay benefits.
- After you satisfy any applicable deductible, you will be responsible for any applicable payment percentage for covered expenses that you incur. You will be responsible for your payment percentage up to the maximum out-of-pocket limit applicable to your plan.
- Your payment percentage will be based on the recognized charge. If the health care provider you select charges more than the recognized charge, you will be responsible for any expenses above the recognized charge, even if you have met the annual maximum out of pocket.
- Once you satisfy any applicable maximum out-of-pocket limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the maximum out-of-pocket limit. Refer to the “Getting Started: Common Terms” section for information on what expenses do not apply. Refer to your “Schedule of Benefits” for specific dollar amounts.
- The plan will pay for covered expenses, up to the maximums shown in the “What the Plan Covers” or “Schedule of Benefits” sections. You are responsible for any expenses incurred over the maximum limits outlined in the “What the Plan Covers” or “Schedule of Benefits” sections.

Understanding Precertification

Precertification

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

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

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

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

The Precertification Process

Prior to being hospitalized or receiving certain other medical services or supplies there are certain precertification procedures that must be followed.

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

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

For non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.
For an emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.

For outpatient non-emergency medical services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
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Aetna will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

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

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

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital;
- Stays in a skilled nursing facility;
- Stays in a rehabilitation facility;
- Stays in a hospice facility;
- Outpatient hospice care;
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse;
- Partial Hospitalization Programs for mental disorders and substance abuse;
- Home health care;
- Private duty nursing care;
- Intensive Outpatient Programs for mental disorders and substance abuse;
- Amytal interview;
- Applied Behavioral Analysis;
- Biofeedback;
- Electroconvulsive therapy;
- Neuropsychological testing;
- Outpatient detoxification;
- Psychiatric home care services;
- Psychological testing.

How Failure to Precertify Affects Your Benefits

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means Aetna will reduce the

amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

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

How Your Benefits are Affected

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

If precertification is:	then the expenses are:
<ul style="list-style-type: none"> ■ requested and approved by Aetna. 	<ul style="list-style-type: none"> ■ covered per the Schedule of Benefits
<ul style="list-style-type: none"> ■ requested and denied. 	<ul style="list-style-type: none"> ■ not covered, may be appealed.
<ul style="list-style-type: none"> ■ not requested, but would have been covered if requested. 	<ul style="list-style-type: none"> ■ covered per the Schedule of Benefits after a precertification benefit reduction is applied.*
<ul style="list-style-type: none"> ■ not requested, would not have been covered if requested. 	<ul style="list-style-type: none"> ■ not covered, may be appealed.

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

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

Emergency and Urgent Care

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

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

In Case of a Medical Emergency

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

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, 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 Reminder:

If you visit a hospital emergency room for a non-emergency condition, the plan may 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.

In Case of an Urgent Condition

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

Coverage for an Urgent Condition

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

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

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

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

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

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

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

Requirements For Coverage

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

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
 - Be included as a covered expense in this Book;
 - Not be an excluded expense under this Book. Refer to the “Exclusions” sections of this Book for a list of services and supplies that are excluded;
 - Not exceed the maximums and limitations outlined in this Book. 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 Book.
2. The service or supply must be provided while coverage is in effect. See the “Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends” and “Continuation of Coverage” sections for details on when coverage begins and ends.
3. The service or supply must be medically necessary. To meet this requirement, the medical services or supply must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
 - a. In accordance with generally accepted standards of medical practice;
 - b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
 - c. Not primarily for the convenience of the patient, physician or other health care provider;
 - d. And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

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

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

What The Plan Covers

Wellness, Physician Services, Hospital Expenses, Other Medical Expenses

Aetna Choice POS II 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.

Routine Physical Exams

Covered expenses include charges made by your physician for routine physical exams, including 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:

- Radiological services, x-rays, lab and other tests given in connection with the exam;
- Immunizations for infectious diseases and the materials for administration of immunizations that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Testing for Tuberculosis.
- For covered newborns, an initial hospital check up.
- Well visits (including routine oral screenings), for covered persons in accordance with the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- The frequency of routine exams for newborns is as follows: 7 visits the first 12 months of life; 3 visits the second 12 months of life; 3 visits the third 12 months of life; and 1 visit per each 12 month period thereafter.

Limitations

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

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

Routine Cancer Screenings

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

- mammograms;
- pap smears;

- gynecological exams;
- fecal occult blood tests;
- digital rectal exams;
- prostate specific antigen (PSA) tests;
- sigmoidoscopies;
- double contrast barium enemas (DCBE); and
- colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines 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.

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.

Important Notices:

1. Refer to the “Schedule of Benefits” for details about cost sharing and benefit maximums that apply to Preventive Care. Updated 1/1/19
2. For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.

Hearing Exam

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

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

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

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

Physician Services

Physician Visits

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

- Immunizations for infectious disease, but not if solely for your employment;

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

Surgery

Covered expenses include charges made by a physician for:

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

Anesthetics

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

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

Alternatives to Physician Office Visits

Walk-In Clinic Visits

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

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

Hospital Expenses

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

Room and Board

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

- Ambulance services.

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

Outpatient Hospital Expenses

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

Important Reminders:

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

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

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

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

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

Coverage for Emergency Medical Conditions

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

The emergency care benefit covers:

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

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

Important Reminder: With the exception of Urgent Care described below, if you visit a

hospital emergency room for a non-emergency condition, the plan will 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.

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 Notice: 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.

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 aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- Medical supplies, prescription drugs and lab services by or for a home health care agency to the extent they would have been covered under this plan if you had continued your hospital stay.

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

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

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

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

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

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

Limitations

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

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.

- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

Important Reminders:

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

Home health care needs to be pre-certified by Aetna. Refer to “How the Plan Works” for details about precertification.

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

Skilled Nursing Facility

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

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

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

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

Limitations

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

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

Hospice Care

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

Facility Expenses

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

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

Outpatient Hospice Expenses

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

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

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

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

Limitations

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

- Daily room and board charges over the semi-private room rate.
- Bereavement counseling.

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

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

Inpatient hospice care and home health care must be pre-certified by Aetna. Refer to “How the Plan Works” for details about precertification.

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.

Autism Spectrum Disorder

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

Eligible health services include the services and supplies provided by a **physician** or **behavioral health provider** for the diagnosis and treatment of Autism Spectrum Disorder. We will only cover this treatment if a **physician** or **behavioral health provider** orders it as part of a treatment plan.

Effective 7/1/19

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.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

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

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over \$500.

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

Limitations

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

Outpatient Diagnostic Lab Work

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

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

Outpatient Diagnostic Radiological Services

Covered expenses include charges for radiological services (other than complex imaging services), 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 services must be provided by a physician, hospital or licensed radiological facility.

Important Reminder: Refer to the “Schedule of Benefits” for details about any deductible, payment percentage and maximum that may apply to outpatient diagnostic radiological

services.

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 Preoperative Testing

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

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

Limitations

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

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

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

Durable Medical and Surgical Equipment (DME)

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

The initial purchase of DME if:

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

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

Replacement of purchased equipment if:

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

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

pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

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

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

Experimental or Investigational Treatment

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures, provided all of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- Aetna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
 - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
 - The clinical trial has passed independent scientific scrutiny and 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 national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
 - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
 - You are treated in accordance with protocol.

Pregnancy Related Expenses

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

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

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

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

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

Prosthetic Devices

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

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

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

Covered expenses also include replacement of a prosthetic device if:

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

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

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators;
- Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet. Coverage for these types of shoes, orthotics or devices is limited to a maximum of two (2) pairs in a calendar year period; 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:

- Trusses, corsets, and other support items;
- There is no coverage for hearing aids or any hearing related services and surgeries under the prosthetic section of this Plan;
- Any item listed in the "Exclusions" section.

Short-Term Rehabilitation Therapy Services

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

have to be performed by:

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

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

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

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

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

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

The therapy should follow a specific treatment plan that:

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

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

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services 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;
- 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 Except this plan will not pay any benefit for the replacement of any hearing loss or defect.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

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

- Surgery to correct a gross anatomical defect present at birth or appearing after birth

(but not the result of an illness or injury) when

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

Reconstructive Breast Surgery

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

Important Notice: A benefit maximum may apply to reconstructive or cosmetic surgery services. Please refer to the “Schedule of Benefits”.

Specialized Care

Chemotherapy

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

Radiation Therapy Benefits

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

Outpatient Infusion Therapy Benefits

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

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

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

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

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

- Enteral nutrition;
- Blood transfusions and blood products;

- Dialysis; and
- Insulin.

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

Coverage for inpatient infusion therapy is provided under the “Inpatient Hospital and Skilled Nursing Facility Benefits” sections of this Book.

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

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

Treatment of Infertility

Basic Infertility Expenses

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

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. This does not apply to in-mouth appliances needed for the treatment of a jaw joint disorder.

Hearing Related Services

See “Schedule of Benefits” for more coverage details. Our coverage for Hearing Related Services is limited to \$2,000 of services every 3 years per member. This allowance will apply to testing and treatment of hearing related injury, illness and disease including the provision of hearing aids and hearing related devices. This includes:

- Bone anchored hearing aids;

- Cochlear implants;
- Any device meant to restore, enhance, or replace your hearing.

This does not include:

- Any hearing service that does not meet professionally accepted standards;
- Hearing exams given during a stay in a hospital or other facility.

Transplant Services

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

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

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

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

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

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

The plan covers:

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

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

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

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

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

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

Important Reminders:

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

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

Limitations

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

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

Network of Transplant Specialist Facilities

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

Alcoholism, Substance Abuse and Mental Disorders Treatment

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

Important Notice: Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the Health Plan “Exclusions and Limits” section for more information.

Wayne County also provides a separate mental health benefit under our Employee Assistance Program (EAP) which is not a part of this Medical Plan. Please see the section for our EAP benefits for more details.

Treatment of Mental Disorders

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

- There is a written treatment plan supervised by a physician or licensed provider; and
- The plan is for a condition that can favorably be changed.

The “Schedule of Benefits” shows the benefits payable and applicable benefit maximums for the treatment of mental disorders.

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

Inpatient Treatment

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

Partial Confinement Treatment

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

Outpatient Treatment

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

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

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

Alcoholism and Substance Abuse

Covered expenses include charges made for the treatment of alcoholism and substance abuse by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider; and
- This plan is for a condition that can be favorably changed.

The “Schedule of Benefits” shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and substance abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

The 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 alcoholism or substance

abuse.

- “Medical complications” include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a hospital, when the hospital does not have a separate treatment facility section.

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or substance abuse.

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 of alcoholism or substance 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 for Alcoholism and Substance Abuse

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 alcoholism or substance abuse.

The partial confinement treatment will only be covered if you would need a hospital stay if you were not admitted to this type of facility.

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

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

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

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

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

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

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

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

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

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

The treatment must be completed in the 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.

Medical Plan Exclusions

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

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 Book.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Book, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

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

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 Book.

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

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

Charges 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;
- any drug, or supply to prevent pregnancy, including: birth control pills, patches and implantable contraceptive drugs; and
- contraceptive devices such as: inter-uterine devices (IUDs) and diaphragms, including initial fitting and insertion.

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

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

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.

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, except as specifically described in the “What The Plan Covers” section.

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.

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;
- Artificial Insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-

cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;

- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

Maintenance Care

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

Miscellaneous charges for services or supplies including:

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

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

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

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

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

Sex Change

Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

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 Book.

Services that are not covered under this Book.

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

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

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body 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.

Transplant-The transplant coverage does not include charges for:

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

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.

Voluntary termination of pregnancy, including related services.

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.

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 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 at the end of the month in which the following occurs 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;
- Your employer notifies Aetna that your employment is ended;
- Your employment is terminated by your own choice;

If a covered employee dies on or after the 15th of any calendar month, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee’s death.

It is your employer’s responsibility to let Aetna know when your employment ends.

Inactive Pay Status

An employee who is not in an active pay status (vacation, comp time, sick, Family Medical Leave) is considered to be Inactive Pay Status and not eligible to be on the Health Plan. Please note that Workers' Comp is not considered active pay status.

- At the point that they are **not** in an active pay status, their insurance eligibility is over and they are terminated from the Health Plan. Please keep in mind that time off does not constitute active pay status for purposes of the Health Plan;
- Members stay on the Health Plan until the end of the month in which they terminate from the Health Plan (for instance, an employee who is terminated from the Health Plan on May 9 would stay on the plan through May 31);
- Employees who return to active pay status within 60 calendar days of the date they are terminated from the Health Plan (using May 31 from the above example) will be able to start back on the Health Plan effective on the date they return to active pay status. They will not have to wait to join the Health Plan like a new employee;
- Employees who return to active pay status 61 or more calendar days from the date they are terminated from the Health Plan will be treated as a new employee for purposes of their effective date on the Health Plan;
- Employees who elect COBRA and are on COBRA on the date of their return to active pay status will start on the Health Plan effective on the date of their return, no matter if their return is over or under 60 days. These employees never left the Health Plan, so they do not have to wait like a new employee.

Examples:

- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on July 15, would be eligible to rejoin the plan with an effective date of July 15 (insurance *always* terms on the last date of the month in which the termination happens, so in this example, since insurance wouldn't have termed until May 31, it has been less than 60 days).
- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on August 15, would be treated as a new employee with regard to the start date on the Health Plan, unless they elected COBRA and were carried by COBRA when they returned (because it has been over 60 days of not being on the health plan).

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees; if a covered employee dies on or after the 15th of any calendar month, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent (examples: divorce, child over 26 years of age, etc.); or

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- As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- PLEASE NOTE that failure to notify Wayne County of a dependent termination, due to not meeting the plan's definition of a dependent, will result in the employee being responsible for 100 percent of any and all claims paid for that dependent after the date which they should have been terminated.*

COBRA benefits may apply to existing and covered dependents. Please refer to Section 7 of the Wayne County Employee Benefit Manual for more information.

Coverage for handicapped dependents may continue after your dependent reaches any limiting age. See Continuation of Coverage for more information.

Continuation of Coverage

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

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

Coverage will cease on the first to occur of:

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

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

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

Other Plans Not Including Medicare

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

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

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

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
 - secondary to the plan covering the person as a dependent; and
 - primary to the plan covering the person as other than a dependent;The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
 - covers the person as other than a dependent; and
 - is secondary to Medicare.
3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.
4. If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
5. In the case of a dependent child whose parents are divorced or separated:
 - a) If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
 - b) If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

- c) If there is not such a court decree:
 - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
- 6. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
 - The benefits of a plan which covers the person on whose expenses claim is based as a:
 - laid-off or retired employee; or
 - the dependent of such person.
 - Shall be determined after the benefits of any other plan which covers such person as:
 - an employee who is not laid-off or retired; or
 - dependent of such person.
 - If the other plan does not have a provision:
 - regarding laid-off or retired employees; and
 - as a result, each plan determines its benefits after the other;
 then the above paragraph will not apply.
 - The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.
 - If the other plan does not have a provision:
 - regarding right of continuation pursuant to federal or state law; and
 - as a result, each plan determines its benefits after the other;
 then the above paragraph will not apply.

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

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

Other Plan

This means any other plan of health expense coverage under:

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

When You Have Medicare Coverage

Which Plan Pays First, How Coordination With Medicare Works, What Is Not Covered

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

Medicare, when used in this Book, 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, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

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

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

The plan is the secondary payor in all other circumstances.

How Coordination with Medicare Works

When the Plan is Primary

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

When Medicare is Primary

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

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

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

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

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

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

Right to Receive and Release Required Information

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

General Provisions

Type of Coverage

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

Physical Examinations

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

Legal Action

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

Additional Provisions

The following additional provisions apply to your coverage:

- This Book 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 Aetna medical benefits plan or about the proper payment of benefits, contact your employer or Aetna.
- The Aetna medical benefits plan may be changed or discontinued with respect to your coverage.

Assignments

Coverage and your rights under this Aetna medical benefits 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 Aetna medical benefits 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 Aetna medical benefits plan.

Subrogation and Right of Recovery Provision

Definitions

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

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

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing

the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First Priority Claim

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

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to

notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

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

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

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 you or on your behalf, ~~or on the behalf of any of your covered dependents~~, 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 a Participant in the Plan. ~~that person or another person in his or her family.~~

Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator – Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the Plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

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

above section updated and effective 7/1/19

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 12 months after the date of the service.

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.

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

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

responsible for filing your own claims.

Records of Expenses

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

Very important are:

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

Contacting Aetna

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

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

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

Discount Programs

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

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

Claims, Appeals and External Review

Claims and Appeals

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 and Appeals 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.

Claims must be submitted for payment to Aetna within one year of the date of service in order to be considered for payment. If a claim is submitted after one year from the date of service it will be denied.

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 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 pursue any available remedies under state law, as applicable.

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 book, 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.

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external

review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds \$500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Aetna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Appeal to the Company

If you choose to appeal to the Company following an adverse determination by External Review where applicable or an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- The specific reason(s) for the appeal;
- Copies of all past correspondence with your Health Plan (including any EOBs); and
- Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize the Company to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Company Name: **Wayne County HR Benefits Specialist**
Company Address: **428 West Liberty Street**
Wooster, Ohio 44691

The Company will review your appeal. The Company reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension. The Company reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The Company reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by the Company with respect to your claim shall be final and binding.

Glossary

This section only provides definitions and does not indicate coverage, or lack of coverage for any item. To determine what is and is not covered, you must carefully read this entire book and the appropriate Schedule of Benefits.

A

Accident

This means a sudden; unexpected; and unforeseen; identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Contract. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.

Aetna

Aetna Life Insurance Company, 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.

B

Behavioral Health Provider/Practitioner

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

Body Mass Index

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

C

Child Support Order

As defined in Ohio Revised Code 3119.01.

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 Book.

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, *Find Care*.

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 a illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have a illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

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

E

Effective Treatment of a Mental Disorder

This is a program that:

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

Emergency Care

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

Emergency Medical Condition

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

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

Experimental or Investigational

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

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

H

Homebound

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

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

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

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

Home Health Care Agency

An agency that meets all of the following requirements.

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

Home Health Care Plan

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

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

Hospice Care

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

Hospice Care Agency

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

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

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

Hospice Care Program

This is a written plan of hospice care, which:

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

Hospice Facility

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

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

Hospital

An institution that:

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

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

Hospitalization

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

I

Illness

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

Infertile or Infertility

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

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

Injury

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

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

Institute of Excellence (IOE)

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

J

Jaw Joint Disorder

This is:

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

L

Late Enrollee

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

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

Limiting Age

For all Children except Step Children the Limiting Age is 26 when they are no longer eligible for coverage under Federal Law, but may be eligible under State Law. For Step Children, the Limiting age is 18 unless they are still eligible under a Child Support Order. They may still be eligible under State Law for other coverage.

L.P.N.

A licensed practical or vocational nurse.

M

Maintenance Care

Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit

Your plan has a maximum out-of-pocket limit. Your deductibles, co-pays, payment percentage 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. There are separate maximum out-of-pocket limits that apply to both network and out-of-network out-of-pocket expenses.

Medically Necessary or Medical Necessity

Health care or dental services, and supplies or prescription drugs that a physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

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

- d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

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

Mental Disorder

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

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

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

Morbid Obesity

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

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

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

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

Network Service(s) or Supply(ies)

Health care service or supply that is:

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

Night Care Treatment

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

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

Non-Occupational Illness

A non-occupational illness is an illness that does not:

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

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

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

Non-Occupational Injury

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

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

Non-Specialist

A physician who is not a specialist.

Non-Urgent Admission

An inpatient admission that is not an emergency admission or an urgent admission.

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.

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

Out-of-Network Service(s) and Supply(ies)

Health care service or supply that is:

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

Out-of-Network Provider

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

P

Partial Confinement Treatment

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

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

Payment Percentage

Payment percentage is both the percentage of covered expenses that the plan pays, and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the

“plan payment percentage,” and varies by the type of expense. Please refer to the “Schedule of Benefits” for specific information on payment percentage amounts.

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.

Primary Care Physician (PCP)

This is the network provider who:

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

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides inpatient-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

Recognized Charge

The covered expense is only that part of a charge which is the recognized charge.

As to medical, vision and hearing expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
 - the 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the recognized charge is the rate established in such agreement.

Aetna may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty

society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area:** This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates:** These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note:

Aetna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the recognized charge is based on the version of the rates that is in use by Aetna on the date that the service or supply was provided.

Additional Information:

Aetna's website aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Member Website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools, or contact our Customer Service Department for assistance.

Rehabilitation Facility

A facility, or a distinct part of a facility which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

Rehabilitative Services

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

Residential Treatment Facility (Alcoholism and Substance Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an

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attending Physician.

- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24-hours perday/7 days a week supervision by a physician with evidence of close and frequent observation.
- On-site, licensed Behavioral Health Provider, medical or substance abuse professionals 24 hours per day/7 days a week.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed

psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.

A registered nurse.

Room and Board

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

S

Semi-Private Room Rate

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

Service Area

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

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
 - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for

residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of Hospitals of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include:

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

Skilled Nursing Services

Services that meet all of the following requirements:

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

Specialist

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

Specialty Care

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

Spouse

Spouse must meet the definition as defined on Page 6, under *Coverage for Spouses*, in this Summary Plan Description.

Stay

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

Step Child

Step Children are natural or adopted children of your spouse who is enrolled under our plan for coverage as your dependent and who is subject to a Child Support Order and the Step Children have not met any of the termination requirements listed under Ohio Revised Code section 3119.88.

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 6 months or less to live.

U

Urgent Admission

A hospital admission by a physician due to:

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

Urgent Care Provider

This is:

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

Urgent Condition

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

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

W

Walk-in Clinic

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

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. ***Our plan does not require, but does allow you to select a PCP.***

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

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

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/HealthInsReformforConsume/>, and this U.S. Department of Labor website, http://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 FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

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

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

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses 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.

Schedule of Benefits

Plan Features	WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE CONSUMER DRIVEN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Calendar Year Deductible*						
Individual Deductible*	\$300	\$500	\$600	\$800	\$1,800	\$1,800
Family Deductible*	\$600	\$1,000	\$1,200	\$1,600	*\$3,600	*\$3,600
					* There is a \$2400 individual deductible within the family deductible both in, and out, of network	
Lifetime Maximum Benefit per person	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

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

Plan Maximum Out of Pocket Limit includes plan deductible.

Plan Features	WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE CONSUMER DRIVEN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Individual Maximum Out of Pocket Limit	For network expenses: \$1,200	For out-of-network expenses: \$2,000	For network expenses: \$2,400	For out-of-network expenses: \$3,200	For network expenses: \$3,000	For out-of-network expenses: \$5,000
Family Maximum Out of Pocket Limit	For network expenses: \$2,400	For out-of-network expenses: \$4,000	For network expenses: \$4,800	For out-of-network expenses: \$6,400	For network expenses: \$6,000	For out-of-network expenses: \$10,000

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

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

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

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

PREVENTIVE CARE BENEFITS						
Routine Physical Exams Includes coverage for immunizations	100% per visit No copay or deductible applies	60% per visit after Calendar Year deductible	100% per visit No copay or deductible applies	60% per visit after Calendar Year deductible	100% per visit No deductible applies	65% per visit after Calendar Year deductible
Maximum Exams per 12 consecutive month period						
Adults age 18 and over	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% per visit No copay or deductible applies	60% per visit after Calendar Year deductible	100% per visit No copay or deductible applies	60% per visit after Calendar Year deductible	100% per visit No copay or deductible applies	65% per visit after Calendar Year deductible
Maximum Exams						
Under age 3						
first 12 months of life	7 exams	7 exams	7 exams	7 exams	7 exams	7 exams
13th-36th months of life	3 exams	3 exams	3 exams	3 exams	3 exams	3 exams
For age 3 to 18	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Hearing Exam	\$20 per exam copay then the plan pays 100% - No Calendar Year deductible applies	60% per exam after Calendar Year deductible	\$30 per exam copay then the plan pays 100% - No Calendar Year deductible applies	60% per exam after Calendar Year deductible	85% per exam after Calendar Year deductible	65% per exam after Calendar Year deductible
Maximum exams per 24 month period	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam

ROUTINE CANCER SCREENINGS						
Routine Gynecological Exam (Includes Routine Pap Smears)	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.	65% per exam after Calendar Year deductible

	WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Maximum exams per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>
All Other Routine Exams and Screenings	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.	60% per exam after Calendar Year deductible	100% per exam No Calendar Year deductible applies.	65% per exam after Calendar Year deductible
Maximum tests per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. <i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN		
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
	<i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>	<i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>	<i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>	<i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>		<i>For details, contact your physician, [log onto the Aetna website www.aetna.com,] or call the number on the back of your ID card.]</i>

PHYSICIAN SERVICES						
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100% No Calendar Year deductible applies	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Specialist Office Visits	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Physician Office Visits-Surgery	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Walk-In Clinics Non-Emergency Visit	\$20 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100% No Calendar Year deductible applies.	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Administration of Anesthesia	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	85% per procedure after Calendar Year deductible	65% per procedure after Calendar Year deductible
Allergy Testing and Treatment	\$20 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

	No Calendar Year deductible applies.		No Calendar Year deductible applies.			
Allergy Injections	80% per visit No Calendar Year deductible applies.	60% per visit No Calendar Year deductible applies.	70% per visit No Calendar Year deductible applies.	60% per visit No Calendar Year deductible applies.	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Immunizations (when not part of the physical exam)	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.	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.	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.
Prenatal 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.	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.	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.
Hearing Related Services \$2,000 limit every 3 years per member	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible

EMERGENCY MEDICAL SERVICES

Hospital Emergency Facility and Physician	\$100 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$100 deductible per visit then the plan pays 100% No Calendar Year deductible applies.	\$200 copay per visit then the plan pays 100% No Calendar Year deductible applies.	\$200 deductible per visit then the plan pays 100% No Calendar Year deductible applies.	85% per visit after the Calendar year deductible	85% per visit after the Calendar year deductible
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Important Note: Please note that some providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and payment percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Important Notice: A separate hospital emergency room deductible or 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 but you will be subject to any inpatient deductibles and co-insurance for your inpatient stay. (This notice does not apply to the High Deductible/Consumer Driven Plan.)

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

URGENT CARE SERVICES						
Urgent Medical Care (at a non-hospital free standing facility)	\$20 copay per visit then the plan pays 100%	60% per visit after Calendar Year deductible	\$30 copay per visit then the plan pays 100%	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
	No Calendar Year deductible applies		No Calendar Year deductible applies			
Urgent Medical Care (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above

OUTPATIENT DIAGNOSTIC AND PREOPERATIVE TESTING
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COMPLEX IMAGING SERVICES						
Complex Imaging	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	85% per procedure after Calendar Year deductible	65% per procedure after Calendar Year deductible

DIAGNOSTIC LABORATORY TESTING						
Diagnostic Laboratory Testing	\$20 per visit copay per procedure then the plan pays 100%	60% per procedure after Calendar Year deductible	\$30 per visit copay per procedure then the plan pays 100%	60% per procedure after Calendar Year deductible	85% per procedure after Calendar Year deductible	65% per procedure after Calendar Year deductible
	No Calendar Year deductible applies.		No Calendar Year deductible applies.			

Important Note: If you have your lab work done by the Wayne County Wellness Nurse, you may not be subject to the copay (and for the High Deductible/Consumer Driven Plan, you may be able to save money). Contact the Wellness Nurse for more details and/or to see if your lab work will qualify for the waived copay!

DIAGNOSTIC X-RAYS (EXCEPT COMPLEX IMAGING SERVICES)						
Diagnostic X-Rays	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	85% per procedure after Calendar Year deductible	65% per procedure after Calendar Year deductible

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

OUTPATIENT SURGERY						
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible	85% per visit/surgical procedure after Calendar Year deductible	65% per visit/surgical procedure after Calendar Year deductible

INPATIENT FACILITY EXPENSES						
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	85% per admission after Calendar Year deductible	65% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	85% per admission after Calendar Year deductible	65% per admission after Calendar Year deductible
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	85% per admission after Calendar Year deductible	65% per admission after Calendar Year deductible
Maximum Days per Calendar Yr	180 days					

SPECIALTY BENEFITS						
Home Health Care (Outpatient)	80% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible	60% per visit after the Calendar Year deductible	85% per visit after the Calendar Year deductible	65% per visit after the Calendar Year deductible
Maximum Visits per Calendar Yr	30 visits					

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

HOSPICE BENEFITS						
Hospice Care - Facility Expenses (Room & Board)	100% per admission No Calendar Year deductible applies	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible			
Hospice Care - Other Expenses during a stay	100% per admission No Calendar Year deductible applies	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible			
Maximum Benefit per lifetime*	360 days	360 days	360 days	360 days	360 days	360 days
<i>*Lifetime maximum is a combined maximum for inpatient and outpatient services.</i>						
Hospice Outpatient Visits	100% per visit No Calendar Year deductible applies	85% per visit after the Calendar Year deductible	65% per visit after the Calendar Year 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	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	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

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

MENTAL DISORDERS						
Office Visits (non-surgical)	\$20 visit copay then the plan pays 100%; No Calendar Year deductible applies	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100%; No Calendar Year deductible applies	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Inpatient Treatment	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible
Maximum Benefit per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Outpatient Treatment	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits

Updated 1/1/19

ALCOHOLISM AND SUBSTANCE ABUSE						
Office Visits (non-surgical)	\$20 visit copay then the plan pays 100%; No Calendar Year deductible applies	60% per visit after Calendar Year deductible	\$30 visit copay then the plan pays 100%; No Calendar Year deductible applies	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
Inpatient Treatment	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible
Maximum Days per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Lifetime Maximum	2 courses of treatment		2 courses of treatment		2 courses of treatment	

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

Outpatient Treatment	80% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible	60% per admission after the Calendar Year deductible	85% per admission after the Calendar Year deductible	65% per admission after the Calendar Year deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits

Important Notice: Both network and out of network alcoholism and substance abuse and mental illness treatment visit limits accumulate toward any maximum shown above for alcoholism and substance abuse and mental illness treatment visit limits.

Updated 1/1/19

TRANSPLANT SERVICES FACILITY AND NON-FACILITY EXPENSES									
	Network (IOE Facility)	Network (Non-IOE Facility)	Out-of-Network	Network (IOE Facility)	Network (Non-IOE Facility)	Out-of-Network	Network (IOE Facility)	Network (Non-IOE Facility)	Out-of-Network
Transplant Facility Expenses	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	100% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	85% per admission after Calendar Year deductible	65% per admission after Calendar Year deductible	65% per admission after Calendar Year 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	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	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	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	Payable in accordance with the type of expense incurred and the place where service is provided

OTHER COVERED HEALTH EXPENSES						
Ground, Air or Water Ambulance	80% after Calendar Year deductible	80% after Calendar Year deductible	70% after Calendar Year deductible	70% after Calendar Year deductible	85% after Calendar Year deductible	85% after Calendar Year deductible
Durable Medical and Surgical Equipment	80% per item after the Calendar Year deductible	60% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible	60% per item after the Calendar Year deductible	85% per item after the Calendar Year deductible	65% per item after the Calendar Year deductible

	WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Jaw Joint Disorder Treatment	80% per visit after Calendar Year deductible* *if not part of an office visit	60% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible* *if not part of an office visit	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
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	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	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
Prosthetic Devices	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	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	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

OUTPATIENT THERAPIES						
Chemo-therapy	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	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	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
Infusion Therapy	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	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	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

WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network

Radiation Therapy	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	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	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
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SHORT TERM OUTPATIENT REHABILITATION THERAPIES						
Outpatient Physical and Occupational Therapy only	\$20 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	\$30 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
	No Calendar Year deductible applies		No Calendar Year deductible applies			
Physical Therapy Maximum visits per Calendar Year	30 visits					
Occupational Therapy Maximum visits per Calendar Year	20 visits					
Speech Therapy only	\$20 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	\$30 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
	No Calendar Year deductible applies		No Calendar Year deductible applies			

	WITH INCENTIVE		WITHOUT INCENTIVE		HIGH DEDUCTIBLE / CONSUMER DRIVEN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Speech Therapy Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits

SPINAL MANIPULATION						
Spinal Manipulation only	\$20 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	\$30 per visit copay then the plan pays 100%	60% per visit after Calendar Year deductible	85% per visit after Calendar Year deductible	65% per visit after Calendar Year deductible
	No Calendar Year deductible applies.		No Calendar Year deductible applies.			
Spinal Manipulation Maximum visits per Calendar Year	20 visits					
Important Notice: Both network and out of network Short Term Outpatient Rehabilitation Therapies visit limits accumulate toward any maximum shown above for Short Term Outpatient Rehabilitation Therapies visit limits.						

Expense Provisions

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

This “Schedule of Benefits” replaces any “Schedule of Benefits” previously in effect under your plan of health benefits.

Deductible Provisions

Network Calendar Year Deductible

This is an amount of network covered expenses incurred each Calendar Year for which no benefits will be paid. The network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible

This is an amount of out-of-network covered expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year deductible applies separately to you and each of your covered dependents. After covered expenses reach the out-of-network Calendar Year deductible, the plan will begin to pay benefits for covered expenses for the rest of the Calendar Year.

Covered expenses applied to the out-of-network deductible will not be applied to satisfy the network deductible and covered expenses applied to the network deductible will not be applied to satisfy the out-of-network deductible.

Network Family Deductible Limit

When you incur network covered expenses that apply toward the network Calendar Year deductibles for you and each of your covered dependents, these expenses will also count toward the network Calendar Year family deductible limit. Your network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the network family deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur out-of-network covered expenses that apply toward the out-of-network Calendar Year deductibles for you and each of your covered dependents, these expenses will also count toward the out-of-network Calendar Year family deductible limit. Your out-of-network family deductible limit will be considered to be met for the rest of the Calendar Year once the combined covered expenses reach the out-of-network family deductible limit in a Calendar Year.

Covered expenses applied to the out-of-network deductible will not be applied to satisfy the network deductible and covered expenses applied to the network deductible will not be applied to satisfy the out-of-network deductible.

Copayments and Benefit Deductible Provisions (does not apply to High Deductible/Consumer Driven Plan)

This is a specified dollar amount or 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.

Payment Percentage

This is the percentage of your covered expenses that the plan pays and the percentage of covered expenses that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable deductibles have been met, your plan will pay a percentage of the covered expenses, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your “Schedule of Benefits” for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for covered expenses during the Calendar Year. Once you satisfy the Maximum Out-of-Pocket Limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the Calendar Year. The Maximum Out-of-Pocket Limit applies to both network and out-of-network benefits.

This plan has an Individual Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for that person.

There is also a Family Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of covered expenses for the remainder of the Calendar Year for all covered family members.

The Maximum Out-of-Pocket Limit applies to both network and out-of-network benefits. You have separate Maximum Out-of-Pocket Limits for in-network and out-of-network benefits. Maximum Out-of-Pocket Limit amounts paid by you for in-network and out-of-network covered expenses apply to each limit separately and may not be combined and applied toward one limit.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan out-of-pocket limit. These include:

- Charges over the recognized charge;
- Expenses incurred for outpatient prescription drugs (this bullet does not apply to High Deductible/Consumer Driven Plan);
- Non-covered expenses;
- Expenses that are not paid, or precertification benefit reductions because a required precertification for the service(s) or supply was not obtained from Aetna.

Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit. The Calendar Year maximum benefit applies to network care and out-of-network care expenses combined.

Precertification Benefit Reduction

The Book contains a complete description of the precertification program. Refer to the “Understanding Precertification” section for a list of services and supplies that require precertification. Failure to precertify your covered expenses when required will result in a benefits reduction as follows:

- A \$500 benefit reduction will be applied separately to each type of expense.

Time Frame to Turn in Claims

All claims must be turned into Aetna for processing within 12 months of the service date. Claims turned in after 12 months from the date of service will not be paid nor considered covered services.

General

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

Special Enrollment Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact your payroll person or Barb Chapin, HR Benefits Specialist at 330.287.5409 or bchapin@wayneohio.org.

<https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf>

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please contact Misty White, Wellness Nurse at 330.287.5487 or wellnessnurse@wayneohio.org, or Barb Chapin, HR Benefits Specialist at 330.287.5409 or bchapin@wayneohio.org.

Forms



**The following pages contain
frequently used forms for your convenience!**

Forms not contained in this section can be found at:

www.aetna.com

**Please photocopy all forms, keeping the
originals in your binder, so that you can
continue to use in future years.**

QUALIFYING EVENT FORM

(for termination or addition to the Wayne County Health Plan)

Employees are not permitted to terminate or add themselves or a dependent to any of the Wayne County Health Plans unless they a) have a Qualifying Event, or b) do so during Open Enrollment (typically October/November of each year). Common Qualifying Events are: marriage, divorce, birth, death, retirement or involuntary loss of coverage (see below for complete list).

If you have a Qualifying Event, you must notify us within 31 days of that Qualifying Event by:

1. Circling the Qualifying Event below;
2. Fill in the dates at the bottom of this form;
3. Sign and date this form;
4. Attach an Enrollment Form with the appropriate fields filled in.

If we do not receive this from you within the 31-day timeframe, you will have to wait until the next Open Enrollment Period or another Qualifying Event to make this change.

Section 125 Changes in Status/2.01 Change in Status –

CIRCLE ONE OF THE FOLLOWING!

With respect to an Employee, any of the following:

- a. Marriage;
- b. Divorce, legal separation or annulment;
- c. Death of the Employee's spouse or child;
- d. Birth, adoption, or placement for adoption of a child;
- e. Termination of the employment of the Employee's spouse or child;
- f. Commencement of the employment of the Employee's spouse or child;
- g. Change from part-time to full-time or from full-time to part-time employment status by the Employee, the Employee's spouse or child (this includes a reduction in hours to less than 30 hours per week);
- h. A strike or lockout reducing the hours of employment of the Employee, the Employee's spouse or child;
- i. Commencement or return from an unpaid leave of absence from employment by the Employee or the Employee's spouse or child;
- j. Significant change in the health coverage of the Employee or the Employee's spouse or child;
- k. A change in the place of residence or work of the Employee, the Employee's spouse or child;
- l. Child of the Employee becoming ineligible for coverage;
- m. Entitlement to Medicare or Medicaid of the Employee, the Employee's spouse or child;
- n. The issuance of a judgment, decree or order that requires accident or health coverage for the Employee's child in the case of dependent care benefits under Article VIII, such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125;
- o. Enrollment of the Employee, Employee's spouse or child in a State or Federal Healthcare exchange.

Date which the qualifying event took place (and circle one of the above options): _____

If your coverage under another plan is ending, please list the last date of that coverage: _____

Date

Employee Signature