

## Appendix A

# BENEFIT PLAN

Prepared Exclusively for  
The Dow Chemical Company

Choice POS II (Home Host/IDS - MAP  
Plus and MAP Plus Aexcel Plus with  
Prescription Drug Plan - Option 1)  
Pre-65 Retirees

What Your Plan  
Covers and How  
Benefits are Paid

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\*Defines the Terms Shown in Bold Type in the Text of This Document.

# Schedule of Benefits

**Employer:** The Dow Chemical Company

**ASA:** 783135

**Control:** 479235

**Issue Date:** February 10, 2016

**Effective Date:** October 1, 2015

**Schedule:** 113A

**Booklet Base:** 113

For: Choice POS II (Home Host/ IDS MAP Plus & MAP Plus Aexcel Plus with Prescription Drug Plan – Option 1) Pre-65 Retirees (Excludes Medicare Retirees)

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Aetna Choice POS II Medical Plan

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>			
Individual Deductible*	\$125	\$125	\$500
Family Deductible*			
Retiree + 1 Dependent Plan	\$250	\$250	\$1,000
Retiree + Family Plan	\$375	\$375	\$1,500
<b>Per Admission Copayment</b>	\$250 per admission*	\$250 per admission*	Not Applicable
*Maximum of \$500 (2 Per Admission Copayments per family per Calendar Year)			
*Unless otherwise indicated, any applicable <b>deductible</b> must be met before benefits are paid.			
<b>Common Accident Deductible</b>	\$125	\$125	\$500

**Plan Maximum Out of Pocket Limit** includes plan deductible, per visit deductibles and copayments.

**Plan Maximum Out of Pocket Limit** excludes precertification penalties.

***Effective October 1, 2015 through December 31, 2015:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,350 maximum.
- For **Aetna network** expenses: 4% of annual salary to \$6,350 maximum
- For **out-of-network** expenses: 8% of annual salary.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$12,700 maximum.
- For **Aetna network** expenses: 8% of annual salary to \$12,700 maximum.
- For **out-of-network** expenses: 12% of annual salary.

***Effective January 1, 2016:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,850 maximum.
- For **Aetna network** expenses: 4% of annual salary to \$6,850 maximum
- For **out-of-network** expenses: 8% of annual salary.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$13,700 maximum.
- For **Aetna network** expenses: 8% of annual salary to \$13,700 maximum.
- For **out-of-network** expenses: 12% of annual salary.

<b><i>Lifetime Maximum Benefit per person</i></b>	Unlimited	Unlimited	Unlimited
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***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.***

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Preventive Care Benefits</i></b>			
<b><i>Routine Physical Exams Office Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit

<b>Preventive Care Immunizations</b> <i>Performed in a facility or physician's office</i>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<b>Screening &amp; Counseling Services</b>  <b>Office Visits</b> <b>Obesity and/or Healthy Diet</b>  <b>Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>  <b>Sexually Transmitted Infections</b>  <b>Genetic Risk for Breast and Ovarian Cancer</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Obesity and/or Healthy Diet</b> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 &amp; older.)</i>	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>			

*Misuse of Alcohol and/or  
Drugs*

Maximum Visits per Calendar Year	5 visits *	5 visits *	5 visits *
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per Calendar Year	Unlimited	Unlimited	Unlimited
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*Sexually Transmitted Infections  
Benefit Maximums*

Maximum Visits per Calendar Year	2 visits*	2 visits*	2 visits*
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**\*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

***Well Woman Preventive Visits  
Office Visits***

100% per visit	100% per visit	100% per visit
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Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations*	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
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\*No age limits for routine ob/gyn exam and pap smear

***Well Woman Preventive Visits***

Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
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<b><i>Routine Cancer Screening Outpatient</i></b>	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
*No Out-of-Network coverage for routine colorectal screenings.			

Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>
*Note: Routine Mammograms, routine Prostate Specific Antigen (PSA) tests and/or Digital Rectal Exams (DRE) are not subject to age or visit limits.			

<b><i>Lung Cancer Screening</i></b>	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	70% per visit after Calendar Year <b>deductible</b>
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<b><i>Lung Cancer Screening Maximum</i></b>	One screening every 12 months*	One screening every 12 months*	One screening every 12 months*
<b>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.</b>			

<b>Prenatal Care Office Visits</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

**Important Note:** Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

***Comprehensive Lactation Support and Counseling Services***

<b>Lactation Counseling Services</b> <i>Facility or Office Visits</i>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6 visits per 12 months	6* visits per 12 months	6 visits per 12 months
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**\*Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the Physician Services office visit section of the *Schedule of Benefits*.

<b>Breast Pumps &amp; Supplies</b>	100% per item	100% per item	100% per item
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

**Important Note:** Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

***Family Planning Services***

Female Contraceptive Counseling Services -Office Visits	100% per visit.	100% per visit.	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months	2* visits per 12 months
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**\*Important Note:** Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

### ***Family Planning Services - Female Contraceptives***

Female Contraceptive Generic <b>Prescription Drugs</b> and Devices provided, administered, or removed, by a <b>Physician</b> during an Office Visits.	100% per item.  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per item.  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per item  No Calendar Year <b>deductible</b> applies.
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### ***Family Planning - Other***

Voluntary Termination of Pregnancy Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Voluntary Sterilization for Males Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

### ***Family Planning - Female Voluntary Sterilization Inpatient***

	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<b><i>Outpatient</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.

<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Vision Care</i></b>			
<b><i>Eye Examinations</i></b> including refraction	100% per exam  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per exam  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per exam  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Physician Services</b>			
<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$20 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b>Applies to Aetna Choice POS II:</b>			
<b>Specialist Office Visits</b>	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b>Applies to Aetna Choice POS II with Aexcel Plus:</b>			
<b>Specialist Office Visits</b>	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>
<b>Aexcel Designated Network Specialist</b>	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable
<b>Non-Designated Network Specialist</b>	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	Not applicable
<b>Out of Network Provider Specialist</b>	Not applicable	Not applicable	70% per visit after Calendar Year <b>deductible</b>

***Applies to Aetna Choice POS II:***

<b><i>Physician Office Visits-Surgery</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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***Applies to Aetna Choice POS II with Aexcel Plus:***

<b><i>Physician Office Visits-Surgery</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
<b><i>Aexcel Designated Network Specialist</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	Not applicable
<b><i>Non-Designated Network Specialist</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	Not applicable
<b><i>Out of Network Provider Specialist</i></b>	Not applicable	Not applicable	70% per visit after Calendar Year <b>deductible</b>

<b>Confirmatory Consultations</b> (Second Opinions)	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
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***Walk-In Clinic Visit (Non-Emergency) Preventive Care Services\****

Immunizations	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	100% per visit  No Calendar Year <b>deductible</b> applies.
Individual Screening and Counseling Services for Tobacco Use	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services

<b><i>Walk-In Clinic Visit (Non-Emergency)</i></b>			
<b><i>Continued</i></b>			
Individual Screening and Counseling Services for Obesity	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
<b>*Important Note:</b> Not all preventive care services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .			
<b><i>All Other Services</i></b>	\$20 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$20 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	70% per visit after Calendar Year <b>deductible</b>

***Applies to Aetna Choice POS II:***

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
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***Applies to Aetna Choice POS II with Aexcel Plus:***

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
<b><i>Aexcel Designated Network Specialist</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	Not applicable
<b><i>Non-Designated Network Specialist</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	Not applicable
<b><i>Out of Network Provider Specialist</i></b>	Not applicable	Not applicable	70% per visit after Calendar Year <b>deductible</b>

<b><i>Administration of Anesthesia</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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<b>Allergy Testing and Treatment</b>	\$10 visit <b>copay</b> then the plan pays 100%*  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible*</b> .	70% per visit after Calendar Year <b>deductible</b> .
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\*100% no **copay** or Calendar Year **deductible** for lab expenses.

<b>Allergy Injections</b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	85% per visit after Calendar Year <b>deductible</b> .	70% per visit after Calendar Year <b>deductible</b> .
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>			
<b>Hospital Emergency Facility and Physician</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	Paid the same as the Network level of benefits.
See Important Note Below			
<p><b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b>), 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 <b>physician</b> 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.</p>			

<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>deductible</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 70%
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<p><b>Important Notice:</b> A separate <b>hospital</b> emergency room <b>deductible</b> or <b>copay</b> applies for each visit to an emergency room for emergency care. If you are admitted to a <b>hospital</b> as an inpatient immediately following a visit to an emergency room, your <b>deductible</b> or <b>copay</b> is waived.</p> <p>Covered expenses that are applied to the emergency room <b>deductible</b> or <b>copay</b> cannot be applied to any other <b>deductible</b> or <b>copay</b> under your plan. Likewise, covered expenses that are applied to any of your plan's other <b>deductibles</b> or <b>copays</b> cannot be applied to the emergency room <b>deductible</b> or <b>copay</b>.</p>			
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## ***Urgent Care Services***

<b><i>Urgent Medical Care</i></b> <i>(at a non-hospital free standing facility)</i>	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>
<b><i>Urgent Medical Care</i></b> <i>(from other than a non-hospital free standing facility)</i>	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.

### **Important Notice:**

A separate **urgent care copay** applies for each visit to a **network urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay** cannot be applied to any other **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **copays** cannot be applied to the **urgent care copay**.

<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
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## ***Outpatient Diagnostic and Preoperative Testing***

### ***Complex Imaging Services***

<b><i>Complex Imaging</i></b>	85% per test after Calendar Year <b>deductible</b>	85% per test after Calendar Year <b>deductible</b>	70% per test after Calendar Year <b>deductible</b>
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### ***Diagnostic Laboratory Testing***

<b><i>Diagnostic Laboratory Testing</i></b>	100% per procedure	100% per procedure	70% per procedure after Calendar Year <b>deductible</b>
	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	

### ***Diagnostic X-Rays (except Complex Imaging Services)***

<b><i>Diagnostic X-Rays</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	70% per visit/surgical procedure after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Facility Expenses</i></b>			
<b><i>Birth Center</i></b>	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.

<b><i>Hospital Facility Expenses</i></b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>
Room and Board (including maternity)			
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>

<b><i>Skilled Nursing Inpatient Facility</i></b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>
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Maximum Days per Calendar Year	Unlimited	Unlimited	180 days*
*Additional days of confinement subject to review for medical necessity.			

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Specialty Benefits</i></b>			
<b><i>Home Health Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
Maximum Visits per Calendar Year	50 visits	50 visits	50 visits

<b><i>Skilled Nursing Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
<b><i>Private Duty Nursing (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
Maximum per <i>Calendar Year</i>	\$15,000	\$15,000	\$15,000

<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care - Facility Expenses</i></b> (Room & Board)	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No Calendar Year <b>deductible</b> applies.
<b><i>Hospice Care - Other Expenses during a stay</i></b>	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days

<b><i>Hospice Outpatient Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit  No Calendar Year <b>deductible</b> applies.
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<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></b> 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.
<b><i>Comprehensive Infertility Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>

Artificial Insemination Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
Ovulation Induction Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
*The maximum of 6 attempts per lifetime is a combined maximum that includes Artificial Insemination and Ovulation Induction.			

<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
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Maximum per lifetime	3 cycles of treatment	3 cycles of treatment	3 cycles of treatment
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Mental Disorders</i></b>			

<b><i>MENTAL DISORDERS</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

## Outpatient Treatment Of Mental Disorders

### Outpatient Services

<b>Office Visits</b>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	70% per visit after the Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	
<b>Other Than Office Visits</b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	70% after the Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
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### Inpatient Treatment of Substance Abuse

#### Hospital Facility Expenses

Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after the Calendar Year <b>deductible</b>
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

#### Inpatient Residential Treatment Facility Expenses

	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>
<b>Inpatient Residential Treatment Facility Expenses Physician Services</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

<i>Outpatient Treatment of Substance Abuse</i>			
<i>Outpatient Treatment</i>			
<i>Office Visits</i>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	
<i>Other Than Office Visits</i>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	70% after Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Non Surgical</i>			
<i>Outpatient Obesity Treatment (non surgical)</i>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>			
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	70% per admission after the Calendar Year <b>deductible</b>
<i>Outpatient Morbid Obesity Surgery</i>	85% per service after Calendar Year <b>deductible</b>	85% per service after Calendar Year <b>deductible</b>	70% per service after Calendar Year <b>deductible</b>
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited

PLAN FEATURES	HOME HOST NETWORK	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>				
<b><i>Transplant Facility Expenses</i></b>	70% per admission after Calendar Year <b>deductible</b>	\$250 per admission copay after Calendar Year <b>deductible</b> , then the plan pays 85%	70% per admission after Calendar Year <b>deductible</b>	70% per admission after Calendar Year <b>deductible</b>
<b><i>Transplant Physician Services</i></b> (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

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Other Covered Health Expenses</i></b>			
<b><i>Acupuncture in lieu of anesthesia</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	70% per procedure after Calendar Year <b>deductible</b>
<b><i>Ground, Air or Water Ambulance</i></b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	70% after Calendar Year <b>deductible</b>
<b><i>Kidney Disease Treatment</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Maximum per visit	Not applicable	Not applicable	\$1,720
<b><i>Diabetic Education</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	\$500	\$500	\$500
<b><i>Durable Medical and Surgical Equipment Includes Orthotics &amp; foot orthotics</i></b>	\$10 per item <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per item after the Calendar Year <b>deductible</b>	70% per item after the Calendar Year <b>deductible</b>

<b><i>Clinical Trial Therapies</i></b> (Experimental or Investigational Treatment)	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.
<b><i>Routine Patient Costs</i></b>	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.
<b><i>Jaw Joint Disorder Treatment</i></b> For non-surgical treatment of TMJ and for TMJ Intra-oral devices	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Maximum Benefit per Lifetime	\$500	\$500	\$500
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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.
<b><i>Prosthetic Devices</i></b>	85% per item after Calendar Year <b>deductible</b>	85% per item after Calendar Year <b>deductible</b>	70% per item after Calendar Year <b>deductible</b>
<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Outpatient Therapies</i></b>			
<b><i>Chemotherapy</i></b>	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.

<b><i>Infusion Therapy</i></b> (Performed in a Physician's Office or Home Care)	\$10 visit <b>copay</b> then the plan pays 100%	85% after Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible applies.</b>		
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	\$10 visit <b>copay</b> then the plan pays 100%	85% after Calendar Year <b>deductible</b>	70% per visit after the Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible applies.</b>		

<b><i>Radiation Therapy</i></b>	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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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Autism Spectrum Disorder</i></b> <b><i>For child to age 18</i></b>			
Autism – Physical therapy	\$10 visit <b>copay</b> then the plan pays 100%	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible applies.</b>		
Autism – Occupational Therapy, Speech Therapy	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Autism – Applied Behavior Analysis Office Visits	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	70% per visit after Calendar Year <b>deductible</b>
	No Calendar Year <b>deductible applies</b>	No Calendar Year <b>deductible applies.</b>	
Autism – Applied Behavior Analysis Other Than Office Visits	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>



PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i> <sup>5</sup>			
<i>Outpatient Physical Therapy</i>	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
<i>Outpatient Occupational Therapy</i>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>

  

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>			
	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% after Calendar Year <b>deductible</b>	70% per visit after Calendar Year <b>deductible</b>
Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits	30 visits

## Pharmacy Benefit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Prescription Drug Calendar Year Deductible</b>		
Individual Deductible*	\$100	\$100
Family Deductible*		
Retiree + 1 Dependent Plan	\$200	\$200
Retiree + Family Plan	\$300	\$300

### Prescription Drug Calendar Year Deductible

The individual **prescription drug** Calendar Year **deductible** applies separately to you and each of your covered dependents. The family **prescription drug** Calendar Year **deductible** applies to you and your covered dependents combined. After **prescription drug covered expenses** reach the **prescription drug** Calendar Year **deductible**, the plan will begin to pay benefits for **prescription drug covered expenses** for the rest of the Calendar Year. The **prescription drug** Calendar Year **deductible** applies to **network** and **out-of-network** **prescription drug covered expenses** combined. The **prescription drug** Calendar Year **deductible** applies to **all** **prescription drug covered expenses** except, drugs dispensed by a **mail-order pharmacy**.

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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*The following Generic Prescription Drugs information applies Effective October 1, 2015 through December 31, 2015:*

<b>Generic Prescription Drugs</b>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable

*The following Generic Prescription Drugs information applies Effective January 1, 2016:*

<b>Generic Prescription Drugs</b>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>		
<b>Formulary Prescription Drugs</b>	20%	20%
<b>Non Formulary Prescription Drugs</b>	30%	30%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>		
<b>Formulary Prescription Drugs</b>	50%	50%
<b>Non Formulary Prescription Drugs</b>	50%	50%
For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy		
<b>Formulary Prescription Drugs</b>	20%	Not Applicable
<b>Non Formulary Prescription Drugs</b>	30%	Not Applicable

<i><b>Preferred Brand-Name Prescription Drugs</b></i>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable
<i><b>Non-Preferred Brand-Name Prescription Drugs</b></i>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>	30%	30%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order <b>pharmacy</b> or a CVS/pharmacy	30%	Not Applicable
<i><b>Preferred Specialty Care Prescription Drug</b></i>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200
<i><b>Non-preferred Specialty Care Prescription Drugs</b></i>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

### **Copay and Deductible Waiver**

#### **Waiver for Risk-Reducing Breast Cancer Prescription Drugs**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

#### **Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs**

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

### Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,
 that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>FDA-Approved Female Generic Over-the-Counter Contraceptives</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
<b>FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
<b>Important Note:</b> This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at <a href="http://www.aetna.com">www.aetna.com</a> or calling the toll-free number on the back of the ID card.		

### ***Preventive Care Drugs and Supplements***

Preventive care drugs and supplements filled at a **pharmacy** with a **prescription**:

100% per item.

Not Covered.

No **copay** or **deductible** applies.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

#### **Important Note:**

Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

### ***Tobacco Cessation Prescription and Over-the-Counter Drugs***

Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply.

100% per supply

Not covered.

No **copay** or **deductible** applies.

#### **Maximums:**

Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

## Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	100% of the recognized charge

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

*The following Precertification and step therapy language applies effective January 1, 2016:*

**Precertification** and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

## Expense Provisions

The following provisions apply to your health expense plan.

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

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

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

## Deductible Provisions

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

### Network Provider Calendar Year Deductible

#### Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

#### Family Deductible Limit

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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

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

## **Out-of-Network Provider Calendar Year Deductible**

### **Individual**

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

### **Family Deductible Limit**

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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

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

### **Common Accident Out-of-Network Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **out-of-network providers**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **out-of-network deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **out-of-network deductible** limit benefit amount paid for the same **covered expenses**.

## **Copayments and Benefit Deductible Provisions**

### **Copayment, Copay**

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.

### **Per Admission Copayment**

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount. Not more than two per admission **copayments** per family will apply for each facility type during a Calendar Year.

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

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will be waived.

## Payment Provisions

### 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. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

### Network Provider Maximum Out-of-Pocket Limit

#### Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

### Out-of Network Provider Maximum Out-of-Pocket Limit

#### Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.



To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

**Covered expenses** that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

#### **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**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

#### **Precertification Benefit Reduction**

The Booklet 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 reduced payment percentage of 20% will apply separately to the eligible expenses incurred for each type of service or supply.

## **General**

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

# Schedule of Benefits

**Employer:** The Dow Chemical Company

**ASA:** 783135

**Control:** 479235

**Issue Date:** February 10, 2016

**Effective Date:** October 1, 2015

**Schedule:** 113B

**Booklet Base:** 113

For: Choice POS II (Home Host/ IDS MAP Plus with Prescription Drug Plan – Option 1 – Out-of-Area) Pre-65 Retirees (Excludes Medicare Retirees)

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Aetna Choice POS II Medical Plan

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>			
Individual Deductible*	\$125	\$125	\$125
Family Deductible*			
Retiree + 1 Dependent Plan	\$250	\$250	\$250
Retiree + Family Plan	\$375	\$375	\$375
<b>Per Admission Copayment</b>	\$250 per admission*	\$250 per admission*	\$250 per admission*
*Maximum of \$500 (2 Per Admission Copayments per family per Calendar Year)			
*Unless otherwise indicated, any applicable <b>deductible</b> must be met before benefits are paid.			
<b>Common Accident Deductible</b>	\$125	\$125	\$125

Plan Maximum Out of Pocket Limit includes plan deductible, per visit deductibles and copayments.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

***Effective October 1, 2015 through December 31, 2015:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,350 maximum.
- For **Aetna network** expenses: 4% of annual salary to \$6,350 maximum
- For **out-of-network** expenses: 4% of annual salary to \$6,350 maximum.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$12,700 maximum.
- For **Aetna network** expenses: 8% of annual salary to \$12,700 maximum.
- For **out-of-network** expenses: 8% of annual salary to \$12,700 maximum.

***Effective January 1, 2016:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,850 maximum.
- For **Aetna network** expenses: 4% of annual salary to \$6,850 maximum
- For **out-of-network** expenses: 4% of annual salary to \$6,850.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$13,700 maximum.
- For **Aetna network** expenses: 8% of annual salary to \$13,700 maximum.
- For **out-of-network** expenses: 8% of annual salary to \$13,700 maximum.

<b><i>Lifetime Maximum Benefit per person</i></b>	Unlimited	Unlimited	Unlimited
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***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.***

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Preventive Care Benefits</i></b>			
<b><i>Routine Physical Exams Office Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit

<b>Preventive Care Immunizations</b> <i>Performed in a facility or physician's office</i>			
	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<b>Screening &amp; Counseling Services</b>			
	100% per visit	100% per visit	100% per visit
<b>Office Visits</b>	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Obesity and/or Healthy Diet</b>			
<b>Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>			
<b>Sexually Transmitted Infections</b>			
<b>Genetic Risk for Breast and Ovarian Cancer</b>			
<b>Obesity and/or Healthy Diet</b> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 &amp; older.)</i>			
	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>			

*Misuse of Alcohol and/or  
Drugs*

Maximum Visits per Calendar Year	5 visits *	5 visits *	5 visits *
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per Calendar Year	Unlimited	Unlimited	Unlimited
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*Sexually Transmitted Infections  
Benefit Maximums*

Maximum Visits per Calendar Year	2 visits*	2 visits*	2 visits*
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**\*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

***Well Woman Preventive Visits  
Office Visits***

	100% per visit	100% per visit	100% per visit
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations*	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

\*No age limits for routine ob/gyn exam and pap smear

***Well Woman Preventive Visits***

Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
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<b><i>Routine Cancer Screening Outpatient</i></b>	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	100% per visit  No copay or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>
*Note: Routine Mammograms, routine Prostate Specific Antigen (PSA) tests and/or Digital Rectal Exams (DRE) are not subject to age or visit limits.			
<b><i>Lung Cancer Screening Maximum</i></b>	One screening every 12 months*	One screening every 12 months*	One screening every 12 months*
<b>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.</b>			
<b><i>Prenatal Care Office Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<b>Important Note:</b> Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.			

**Comprehensive Lactation Support and Counseling Services**

<b>Lactation Counseling Services</b> <i>Facility or Office Visits</i>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6 visits per 12 months	6* visits per 12 months	6 visits per 12 months
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**\*Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the Physician Services office visit section of the *Schedule of Benefits*.

<b>Breast Pumps &amp; Supplies</b>	100% per item	100% per item	100% per item
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

**Important Note:** Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

**Family Planning Services**

Female Contraceptive Counseling Services -Office Visits	100% per visit.	100% per visit.	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months	2* visits per 12 months
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**\*Important Note:** Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

**Family Planning Services - Female Contraceptives**

Female Contraceptive Generic <b>Prescription Drugs</b> and Devices provided, administered, or removed, by a <b>Physician</b> during an Office Visits.	100% per item.	100% per item.	100% per item
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.



<b>Family Planning - Other</b>			
Voluntary Termination of Pregnancy			
Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Voluntary Sterilization for Males			
Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

<b>Family Planning - Female Voluntary Sterilization</b>			
<b>Inpatient</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Outpatient</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Vision Care</b>			
<b>Eye Examinations</b> including refraction	100% per exam	100% per exam	100% per exam
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Physician Services</b>			
<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	\$10 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>deductible</b> then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b>Specialist Office Visits</b>	\$10 visit <b>copay</b> then the plan pays 100%	\$50 visit <b>copay</b> then the plan pays 100%	\$50 visit <b>deductible</b> then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.

<b>Physician Office Visits-Surgery</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b>Confirmatory Consultations</b> (Second Opinions)	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<b>Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*</b>			
Immunizations	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.  For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	100% per visit  No Calendar Year <b>deductible</b> applies.
Individual Screening and Counseling Services for Tobacco Use	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
<b>*Important Note:</b> Not all preventive care services are available at all <b>Walk-In Clinics</b> . The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your <b>physician</b> .			

<b><i>Walk-In Clinic Visit (Non-Emergency)</i></b>			
<b><i>Continued</i></b>			
<b><i>All Other Services</i></b>	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit deductible then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Administration of Anesthesia</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<b><i>Allergy Testing and Treatment</i></b>			
Primary Care Physician	\$10 visit <b>copay</b> then the plan pays 100%*	85% per visit after Calendar Year <b>deductible*</b> .	85% per visit after Calendar Year <b>deductible*</b>
	No Calendar Year <b>deductible</b> applies.		
<b><i>Specialist</i></b>	\$10 visit <b>copay</b> then the plan pays 100%*	85% per visit after Calendar Year <b>deductible*</b> .	85% per visit after Calendar Year <b>deductible*</b>
	No Calendar Year <b>deductible</b> applies.		
*100% no <b>copay</b> or Calendar Year <b>deductible</b> for lab expenses.			
<b><i>Allergy Injections</i></b>	100% per visit	85% per visit after Calendar Year <b>deductible</b> .	85% per visit after Calendar Year <b>deductible</b> .
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.		

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>			
<b>Hospital Emergency Facility and Physician</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	Paid the same as the Network level of benefits.
See Important Note Below			
<b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b> , the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b> ), 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 <b>physician</b> 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.			
<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>deductible</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%
<b>Important Notice:</b> A separate <b>hospital</b> emergency room <b>deductible</b> or <b>copay</b> applies for each visit to an emergency room for emergency care. If you are admitted to a <b>hospital</b> as an inpatient immediately following a visit to an emergency room, your <b>deductible</b> or <b>copay</b> is waived.  Covered expenses that are applied to the emergency room <b>deductible</b> or <b>copay</b> cannot be applied to any other <b>deductible</b> or <b>copay</b> under your plan. Likewise, covered expenses that are applied to any of your plan's other <b>deductibles</b> or <b>copays</b> cannot be applied to the emergency room <b>deductible</b> or <b>copay</b> .			
<b>Urgent Care Services</b>			
<b>Urgent Medical Care</b> (at a non-hospital free standing facility)	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	\$20 deductible per visit after the Calendar Year <b>deductible</b> then the plan pays 100%
<b>Urgent Medical Care</b> (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.

**Important Notice:**

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Outpatient Diagnostic and Preoperative Testing</i>			
<i>Complex Imaging Services</i>			
<i>Complex Imaging</i>	85% per test after Calendar Year <b>deductible</b>	85% per test after Calendar Year <b>deductible</b>	85% per test after Calendar Year <b>deductible</b>
<i>Diagnostic Laboratory Testing</i>			
<i>Diagnostic Laboratory Testing</i>	100% per procedure  No copay or Calendar Year <b>deductible</b> apply.	100% per procedure  No copay or Calendar Year <b>deductible</b> apply.	100% per procedure  No Calendar Year <b>deductible</b> applies.
<i>Diagnostic X-Rays (except Complex Imaging Services)</i>			
<i>Diagnostic X-Rays</i>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>			
<i>Outpatient Surgery</i>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>			
<i>Birth Center</i>	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.

<b><i>Hospital Facility Expenses</i></b> Room and Board (including maternity)	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
<b><i>Skilled Nursing Inpatient Facility</i></b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Maximum Days per Calendar Year	Unlimited	Unlimited	Unlimited
<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Specialty Benefits</i></b>			
<b><i>Home Health Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Maximum Visits per Calendar Year	50 visits	50 visits	50 visits
<b><i>Skilled Nursing Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
<b><i>Private Duty Nursing (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Maximum per <i>Calendar Year</i>	\$15,000	\$15,000	\$15,000

<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care - Facility Expenses</i></b> (Room & Board)	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No Calendar Year <b>deductible</b> applies.
<b><i>Hospice Care - Other Expenses during a stay</i></b>	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
<b><i>Hospice Outpatient Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit  No Calendar Year <b>deductible</b> applies.
<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></b> 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.
<b><i>Comprehensive Infertility Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
Artificial Insemination Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
Ovulation Induction Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
*The maximum of 6 attempts per lifetime is a combined maximum that includes Artificial Insemination and Ovulation Induction.			
<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
Maximum per lifetime	3 cycles of treatment	3 cycles of treatment	3 cycles of treatment

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>			
<b>MENTAL DISORDERS</b>			
<i>Hospital Facility Expenses</i>			
Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<i>Inpatient Residential Treatment Facility Expenses</i>			
	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<i>Outpatient Treatment Of Mental Disorders</i>			
<i>Outpatient Services</i>			
<i>Office Visits</i>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>deductible then the plan pays 100%</b>
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<i>Other Than Office Visits</i>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after the Calendar Year <b>deductible</b>



PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Substance Abuse</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after the Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>			
	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
<b><i>Office Visits</i></b>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit deductible then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Non Surgical</b>			

<b>Outpatient Obesity Treatment (non surgical)</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Surgical</b>			

<b>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after the Calendar Year <b>deductible</b> then the plan pays 85%
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<b>Outpatient Morbid Obesity Surgery</b>	85% per service after Calendar Year <b>deductible</b>	85% per service after Calendar Year <b>deductible</b>	85% per service after Calendar Year <b>deductible</b>
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited
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PLAN FEATURES	HOME HOST NETWORK	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
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<b>Transplant Services Facility and Non-Facility Expenses</b>				
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<b>Transplant Facility Expenses</b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> , then the plan pays 85%
<b>Transplant Physician Services</b> (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

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>			
<i>Acupuncture in lieu of anesthesia</i>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<i>Ground, Air or Water Ambulance</i>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>
<i>Kidney Disease Treatment</i>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Maximum per visit	Not applicable	Not applicable	\$1,720
<i>Diabetic Education</i>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	\$500	\$500	\$500
<i>Durable Medical and Surgical Equipment Includes Orthotics &amp; foot orthotics</i>	\$10 per item <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per item after the Calendar Year <b>deductible</b>	85% per item after the Calendar Year <b>deductible</b>
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	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.
<i>Routine Patient Costs</i>	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.

<b><i>Jaw Joint Disorder Treatment</i></b> For non-surgical treatment of TMJ and for TMJ Intra-oral devices	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Maximum Benefit per Lifetime	\$500	\$500	\$500
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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.
<b><i>Orthotic and Prosthetic Devices</i></b>	85% per item after Calendar Year <b>deductible</b>	85% per item after Calendar Year <b>deductible</b>	85% per item after Calendar Year <b>deductible</b>
<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Outpatient Therapies</i></b>			
<b><i>Chemotherapy</i></b>	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.
<b><i>Infusion Therapy</i></b> (Performed in a Physician's Office or Home Care)	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible applies.</b>	85% after Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible applies.</b>	85% after Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
<b><i>Radiation Therapy</i></b>	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.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Autism Spectrum Disorder For child to age 18</i></b>			
Autism – Physical therapy	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Autism – Occupational Therapy, Speech Therapy	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Autism – Applied Behavior Analysis Office Visits	\$50 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	\$50 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 per visit <b>deductible then the plan pays 100%</b>  No Calendar Year <b>deductible</b> applies.
Autism – Applied Behavior Analysis Other Than Office Visits	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies <sup>5</sup></i></b>			
<b><i>Outpatient Physical Therapy</i></b>	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Occupational Therapy</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Spinal Manipulation</i></b>			
	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits	30 visits

# Pharmacy Benefit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Prescription Drug Calendar Year Deductible</b>		
Individual Deductible*	\$100	\$100
Family Deductible*		
Retiree + 1 Dependent Plan	\$200	\$200
Retiree + Family Plan	\$300	\$300

## Prescription Drug Calendar Year Deductible

The individual **prescription drug** Calendar Year **deductible** applies separately to you and each of your covered dependents. The family **prescription drug** Calendar Year **deductible** applies to you and your covered dependents combined. After **prescription drug covered expenses** reach the **prescription drug** Calendar Year **deductible**, the plan will begin to pay benefits for **prescription drug covered expenses** for the rest of the Calendar Year. The **prescription drug** Calendar Year **deductible** applies to **network** and **out-of-network prescription drug covered expenses** combined. The **prescription drug** Calendar Year **deductible** applies to **all prescription drug covered expenses** except, drugs dispensed by a **mail-order pharmacy**.

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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*The following Generic Prescription Drugs information applies Effective October 1, 2015 through December 31, 2015:*

<b>Generic Prescription Drugs</b>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable

*The following Generic Prescription Drugs information applies Effective January 1, 2016:*

### **Generic Prescription Drugs**

For each initial 30 day supply filled  
at a retail **pharmacy**

<b>Formulary Prescription Drugs</b>	20%	20%
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<b>Non Formulary Prescription Drugs</b>	30%	30%
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This applies to all refills after the  
second refill of a 30 day supply filled  
at a retail **pharmacy**

<b>Formulary Prescription Drugs</b>	50%	50%
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<b>Non Formulary Prescription Drugs</b>	50%	50%
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For all fills of a 90 day supply filled  
at a **mail order pharmacy** or a  
CVS/pharmacy

<b>Formulary Prescription Drugs</b>	20%	Not Applicable
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<b>Non Formulary Prescription Drugs</b>	30%	Not Applicable
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### **Preferred Brand-Name Prescription Drugs**

For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
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This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
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For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable
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### **Non-Preferred Brand-Name Prescription Drugs**

For each initial 30 day supply filled at a retail <b>pharmacy</b>	30%	30%
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This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
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For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order <b>pharmacy</b> or a CVS/pharmacy	30%	Not Applicable
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<b><i>Preferred Specialty Care Prescription Drug</i></b>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200
<b><i>Non-preferred Specialty Care Prescription Drugs</i></b>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

### **Copay and Deductible Waiver**

#### **Waiver for Risk-Reducing Breast Cancer Prescription Drugs**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

#### **Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs**

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

#### **Waiver for Prescription Drug Contraceptives**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,
 that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.



PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>FDA-Approved Female Generic Over-the-Counter Contraceptives</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
<b>FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.

**Important Note:**

This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at [www.aetna.com](http://www.aetna.com) or calling the toll-free number on the back of the ID card.

***Preventive Care Drugs and Supplements***

Preventive care drugs and supplements filled at a <b>pharmacy</b> with a <b>prescription</b> :	100% per item.  No <b>copay</b> or <b>deductible</b> applies.	Not Covered.
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Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

**Important Note:**

Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

## Preventive Care Drugs and Supplements Continued

### ***Tobacco Cessation Prescription and Over-the-Counter Drugs***

Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b> for each 90 day supply.	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
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#### Maximums:

Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

## Coinsurance

	NETWORK	OUT-OF-NETWORK
<b>Prescription Drug Plan Coinsurance</b>	100% of the <b>negotiated charge</b>	100% of the <b>recognized charge</b>

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

***The following Precertification and step therapy language applies effective January 1, 2016:***

**Precertification** and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

## Expense Provisions

**The following provisions apply to your health expense plan.**

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

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

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

### **Deductible Provisions**

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

### **Network Provider Calendar Year Deductible**

#### **Individual**

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

#### **Family Deductible Limit**

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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

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

### **Out-of-Network Provider Calendar Year Deductible**

#### **Individual**

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

#### **Family Deductible Limit**

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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

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

### **Common Accident Out-of-Network Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **out-of-network providers**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **out-of-network deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **out-of-network deductible** limit benefit amount paid for the same **covered expenses**.

## **Copayments and Benefit Deductible Provisions**

### **Copayment, Copay**

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.

### **Per Admission Copayment**

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount. Not more than two per admission **copayments** per family will apply for each facility type during a Calendar Year.

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

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will be waived.

## **Payment Provisions**

### **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. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

### **Network Provider Maximum Out-of-Pocket Limit**

#### **Individual**

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### **Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

### **Out-of-Network Provider Maximum Out-of-Pocket Limit**

#### **Individual**

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### **Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

**Covered expenses** that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

### **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**;
- Non-covered expenses;

- Any **covered expenses** which are payable by **Aetna** at 50%; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

### **Precertification Benefit Reduction**

The Booklet 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 reduced payment percentage of 20% will apply separately to the eligible expenses incurred for each type of service or supply.

### **General**

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

# Schedule of Benefits

**Employer:** The Dow Chemical Company

**ASA:** 783135

**Control:** 479235

**Issue Date:** February 10, 2016

**Effective Date:** October 1, 2015

**Schedule:** 113C

**Booklet Base:** 113

For: Choice POS II (Home Host/ IDS MAP Plus with Prescription Drug Plan – Option 1 – Out-of-Area Passive Plan) Pre-65 Retirees (Excludes Medicare Retirees)

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

## Aetna Choice POS II Medical Plan

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Calendar Year Deductible*</b>			
Individual Deductible*	\$250	\$250	\$250
Family Deductible*			
Retiree + 1 Dependent Plan	\$500	\$500	\$500
Retiree + Family Plan	\$750	\$750	\$750
<b>Per Admission Copayment</b>	\$250 per admission*	\$250 per admission*	\$250 per admission*
*Maximum of \$500 (2 Per Admission Copayments per family per Calendar Year)			
*Unless otherwise indicated, any applicable <b>deductible</b> must be met before benefits are paid.			
<b>Common Accident Deductible</b>	\$250	\$250	\$250

**Plan Maximum Out of Pocket Limit** includes plan **deductible, per visit deductibles** and **copayments**.

**Plan Maximum Out of Pocket Limit** excludes **precertification** penalties.

***Effective October 1, 2015 through December 31, 2015:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,350 maximum.
- For Aetna **network** expenses: 4% of annual salary to \$6,350 maximum
- For **out-of-network** expenses: 4% of annual salary to \$6,350 maximum.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$12,700 maximum.
- For Aetna **network** expenses: 8% of annual salary to \$12,700 maximum.
- For **out-of-network** expenses: 8% of annual salary to \$12,700 maximum.

***Effective January 1, 2016:***

**Individual Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 4% of annual salary to \$6,850 maximum.
- For Aetna **network** expenses: 4% of annual salary to \$6,850 maximum
- For **out-of-network** expenses: 4% of annual salary to \$6,850.

**Family Maximum Out of Pocket Limit:**

- For **Home Host network** expenses: 8% of annual salary to \$13,700 maximum.
- For Aetna **network** expenses: 8% of annual salary to \$13,700 maximum.
- For **out-of-network** expenses: 8% of annual salary to \$13,700 maximum.

<b><i>Lifetime Maximum Benefit per person</i></b>	Unlimited	Unlimited	Unlimited
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***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.***



PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Preventive Care Benefits</b>			
<b><i>Routine Physical Exams Office Visits</i></b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	100% per visit  No Calendar Year <b>deductible</b> applies.
<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.  <i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	1 visit	1 visit

<b>Preventive Care Immunizations</b> <i>Performed in a facility or physician's office</i>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>	<i>For details, contact your <b>physician</b> or Member Services by logging onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i>
<b>Screening &amp; Counseling Services</b>  <b>Office Visits</b> <b>Obesity and/or Healthy Diet</b>  <b>Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>  <b>Sexually Transmitted Infections</b>  <b>Genetic Risk for Breast and Ovarian Cancer</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Obesity and/or Healthy Diet</b> Maximum Visits per Calendar Year <i>(This maximum applies only to Covered Persons ages 22 &amp; older.)</i>	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>			

*Misuse of Alcohol and/or  
Drugs*

Maximum Visits per Calendar Year	5 visits *	5 visits *	5 visits *
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**\*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

*Use of Tobacco Products*

Maximum Visits per Calendar Year	Unlimited	Unlimited	Unlimited
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*Sexually Transmitted Infections  
Benefit Maximums*

Maximum Visits per Calendar Year	2 visits*	2 visits*	2 visits*
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**\*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.**

***Well Woman Preventive Visits  
Office Visits***

	100% per visit	100% per visit	100% per visit
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations*	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

\*No age limits for routine ob/gyn exam and pap smear

***Well Woman Preventive Visits***

Maximum Visits per Calendar Year	1 visit	1 visit	1 visit
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***Routine Cancer Screening  
Outpatient***

	100% per visit	100% per visit	100% per visit
	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> <li>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</li> <li>the comprehensive guidelines supported by the Health Resources and Services Administration.*</li> </ul> <p><i>For details, contact your <b>physician</b> or Member Services by logging onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or calling the number on the back of your ID card.</i></p>
<p>*Note: Routine Mammograms, routine Prostate Specific Antigen (PSA) tests and/or Digital Rectal Exams (DRE) are not subject to age or visit limits.</p>			

<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*	One screening every 12 months*
<p><b>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.</b></p>			

<b>Prenatal Care Office Visits</b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<p><b>Important Note:</b> Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.</p>			

<b>Comprehensive Lactation Support and Counseling Services</b>			
<b>Lactation Counseling Services</b> <i>Facility or Office Visits</i>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6 visits per 12 months	6* visits per 12 months	6 visits per 12 months
<b>*Important Note:</b> Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the Physician Services office visit section of the <i>Schedule of Benefits</i> .			
<b>Breast Pumps &amp; Supplies</b>	100% per item	100% per item	100% per item
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Important Note:</b> Refer to the <i>Comprehensive Lactation Support and Counseling Services</i> section of the Booklet for limitations on breast pumps and supplies.			
<b>Family Planning Services</b>			
Female Contraceptive Counseling Services -Office Visits	100% per visit.	100% per visit.	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	2* visits per 12 months	2* visits per 12 months
<b>*Important Note:</b> Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .			
<b>Family Planning Services - Female Contraceptives</b>			
Female Contraceptive Generic <b>Prescription Drugs</b> and Devices provided, administered, or removed, by a <b>Physician</b> during an Office Visits.	100% per item.	100% per item.	100% per item
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b>Family Planning - Other</b>			
Voluntary Termination of Pregnancy Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Voluntary Sterilization for Males Outpatient	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

<b><i>Family Planning - Female Voluntary Sterilization</i></b>	100% per visit	100% per visit	100% per visit
<b><i>Inpatient</i></b>	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
<b><i>Outpatient</i></b>	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Vision Care</i></b>			
<b><i>Eye Examinations</i></b> including refraction	100% per exam	100% per exam	100% per exam
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	1 exam	1 exam	1 exam

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Physician Services</i></b>			
<b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non-specialist	\$10 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>deductible</b> then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Specialist Office Visits</i></b>	\$10 visit <b>copay</b> then the plan pays 100%	\$50 visit <b>copay</b> then the plan pays 100%	\$50 visit <b>deductible</b> then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Physician Office Visits-Surgery</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b>Confirmatory Consultations</b> (Second Opinions)	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

**Walk-In Clinic Visit (Non-Emergency)****Preventive Care Services\***

Immunizations	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
	For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	For details, contact your <b>physician</b> , log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a> , or call the number on the back of your ID card.	
Individual Screening and Counseling Services for Tobacco Use	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit	100% per visit	100% per visit
	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No <b>copay</b> or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services

**\*Important Note:**

Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

<b>All Other Services</b>	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit <b>copay</b> then the plan pays 100%	\$20 visit deductible then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.

<b>Physician Services for Inpatient Facility and Hospital Visits</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
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<b>Administration of Anesthesia</b>	85% per visit after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
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<b>Allergy Testing and Treatment</b>	\$10 visit <b>copay</b> then the plan pays 100%*  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b> .*	85% per visit after Calendar Year <b>deductible</b> .*
*100% no <b>copay</b> or Calendar Year <b>deductible</b> for lab expenses.			

<b>Allergy Injections</b>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> apply.	85% per visit after Calendar Year <b>deductible</b> .	85% per visit after Calendar Year <b>deductible</b> .
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>			
<b>Hospital Emergency Facility and Physician</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	Paid the same as the Network level of benefits.
See Important Note Below			
<b>Important Note:</b> Please note that as these providers are not <b>network providers</b> and do not have a contract with <b>Aetna</b> , the provider may not accept payment of your cost share (your <b>deductible</b> and <b>payment percentage</b> ), 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 <b>physician</b> 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.			

<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%	\$100 <b>deductible</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 85%
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**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 **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

***Urgent Care Services***

<b><i>Urgent Medical Care</i></b> <i>(at a non-hospital free standing facility)</i>	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	\$20 <b>copay</b> per visit after the Calendar Year <b>deductible</b> then the plan pays 100%	\$20 deductible per visit after the Calendar Year <b>deductible</b> then the plan pays 100%
<b><i>Urgent Medical Care</i></b> <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services and Physician Services</i> above.	Refer to <i>Emergency Medical Services and Physician Services</i> above.	Refer to <i>Emergency Medical Services and Physician Services</i> above.

**Important Notice:**

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

**PLAN FEATURES****HOME HOST  
NETWORK****AETNA NETWORK****OUT-OF-NETWORK*****Outpatient Diagnostic and Preoperative Testing******Complex Imaging Services***

<b><i>Complex Imaging</i></b>	85% per test after Calendar Year <b>deductible</b>	85% per test after Calendar Year <b>deductible</b>	85% per test after Calendar Year <b>deductible</b>
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***Diagnostic Laboratory Testing***

<b><i>Diagnostic Laboratory Testing</i></b>	100% per procedure	100% per procedure	100% per procedure
	No copay or Calendar Year <b>deductible</b> apply.	No copay or Calendar Year <b>deductible</b> apply.	No Calendar Year <b>deductible</b> applies.

<b><i>Diagnostic X-Rays (except Complex Imaging Services)</i></b>			
<b><i>Diagnostic X-Rays</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Surgery</i></b>			
<b><i>Outpatient Surgery</i></b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>	85% per visit/surgical procedure after Calendar Year <b>deductible</b>
PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Facility Expenses</i></b>			
<b><i>Birthing Center</i></b>	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.
<b><i>Hospital Facility Expenses</i></b> Room and Board (including maternity)	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
<b><i>Skilled Nursing Inpatient Facility</i></b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Maximum Days per Calendar Year	Unlimited	Unlimited	Unlimited

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Specialty Benefits</i></b>			
<b><i>Home Health Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Maximum Visits per Calendar Year	50 visits	50 visits	50 visits
<b><i>Skilled Nursing Care (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
<b><i>Private Duty Nursing (Outpatient)</i></b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Maximum per <i>Calendar Year</i>	\$15,000	\$15,000	\$15,000
<b><i>Hospice Benefits</i></b>			
<b><i>Hospice Care - Facility Expenses</i></b> (Room & Board)	100% per admission No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission No Calendar Year <b>deductible</b> applies.
<b><i>Hospice Care - Other Expenses during a stay</i></b>	100% per admission No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per admission No Calendar Year <b>deductible</b> applies.
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days
<b><i>Hospice Outpatient Visits</i></b>	100% per visit No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit No <b>copay</b> or Calendar Year <b>deductible</b> apply	100% per visit No Calendar Year <b>deductible</b> applies.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Infertility Treatment</i></b>			
<b><i>Basic Infertility Expenses</i></b> 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.
<b><i>Comprehensive Infertility Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
Artificial Insemination Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
Ovulation Induction Lifetime Maximum Benefit	6 cycles of treatment*	6 cycles of treatment*	6 cycles of treatment*
*The maximum of 6 attempts per lifetime is a combined maximum that includes Artificial Insemination and Ovulation Induction.			
<b><i>Advanced Reproductive Technology (ART) Expenses</i></b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
Maximum per lifetime	3 cycles of treatment	3 cycles of treatment	3 cycles of treatment

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Mental Disorders</i></b>			
<b><i>MENTAL DISORDERS</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>			
	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Treatment Of Mental Disorders</i></b>			
<b><i>Outpatient Services</i></b>			
<b><i>Office Visits</i></b>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>deductible then the plan pays 100%</b>
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after the Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Substance Abuse</i></b>			
<b><i>Hospital Facility Expenses</i></b>			
Room and Board	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after the Calendar Year <b>deductible</b> then the plan pays 85%
Other than Room and Board	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>	85% per admission after Calendar Year <b>deductible</b>
Physician Services	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>			
	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> then the plan pays 85%
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Treatment of Substance Abuse</i></b>			
<b><i>Outpatient Treatment</i></b>			
<b><i>Office Visits</i></b>	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit <b>copay</b> then the plan pays 100%	\$50 per visit deductible then the plan pays 100%
	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.	No Calendar Year <b>deductible</b> applies.
<b><i>Other Than Office Visits</i></b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Non Surgical</b>			

<b>Outpatient Obesity Treatment (non surgical)</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
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PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b>Obesity Treatment Surgical</b>			

<b>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> then the plan pays 85%	\$250 per admission <b>deductible</b> after the Calendar Year <b>deductible</b> then the plan pays 85%
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<b>Outpatient Morbid Obesity Surgery</b>	85% per service after Calendar Year <b>deductible</b>	85% per service after Calendar Year <b>deductible</b>	85% per service after Calendar Year <b>deductible</b>
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Unlimited
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PLAN FEATURES	HOME HOST NETWORK	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
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<b>Transplant Services Facility and Non-Facility Expenses</b>				
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<b>Transplant Facility Expenses</b>	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>copay</b> after Calendar Year <b>deductible</b> , then the plan pays 85%	\$250 per admission <b>deductible</b> after Calendar Year <b>deductible</b> , then the plan pays 85%
<b>Transplant Physician Services</b> (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

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>			
<i>Acupuncture in lieu of anesthesia</i>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>	85% per procedure after Calendar Year <b>deductible</b>
<i>Ground, Air or Water Ambulance</i>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>	85% after Calendar Year <b>deductible</b>
<i>Kidney Disease Treatment</i>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Maximum per visit	Not applicable	Not applicable	\$1,720
<i>Diabetic Education</i>	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No <b>copay</b> or Calendar Year <b>deductible</b> applies.	100% per visit  No Calendar Year <b>deductible</b> applies.
Maximum Benefit per Calendar Year	\$500	\$500	\$500
<i>Durable Medical and Surgical Equipment Includes Orthotics &amp; foot orthotics</i>	\$10 per item <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per item after the Calendar Year <b>deductible</b>	85% per item after the Calendar Year <b>deductible</b>
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	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.
<i>Routine Patient Costs</i>	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.



<b><i>Jaw Joint Disorder Treatment</i></b> For non-surgical treatment of TMJ and for TMJ Intra-oral devices	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Maximum Benefit per Lifetime	\$500	\$500	\$500
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	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.
<b><i>Orthotic and Prosthetic Devices</i></b>	85% per item after Calendar Year <b>deductible</b>	85% per item after Calendar Year <b>deductible</b>	85% per item after Calendar Year <b>deductible</b>
<b>PLAN FEATURES</b>	<b>HOME HOST NETWORK</b>	<b>AETNA NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Outpatient Therapies</i></b>			
<b><i>Chemotherapy</i></b>	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.
<b><i>Infusion Therapy</i></b> (Performed in a Physician's Office or Home Care)	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible applies.</b>	85% after Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
Performed in a Hospital Outpatient Department or Non-Hospital Outpatient Facility	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible applies.</b>	85% after Calendar Year <b>deductible</b>	85% per visit after the Calendar Year <b>deductible</b>
<b><i>Radiation Therapy</i></b>	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.

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Autism Spectrum Disorder For child to age 18</i></b>			
Autism – Physical therapy	\$10 visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Autism – Occupational Therapy, Speech Therapy	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Autism – Applied Behavior Analysis Office Visits	\$50 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies	\$50 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	\$50 per visit <b>deductible then the plan pays 100%</b>  No Calendar Year <b>deductible</b> applies.
Autism – Applied Behavior Analysis Other Than Office Visits	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies <sup>5</sup></i></b>			
<b><i>Outpatient Physical Therapy</i></b>	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
<b><i>Outpatient Occupational Therapy</i></b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>

PLAN FEATURES	HOME HOST NETWORK	AETNA NETWORK	OUT-OF-NETWORK
<b><i>Spinal Manipulation</i></b>			
	\$10 per visit <b>copay</b> then the plan pays 100%  No Calendar Year <b>deductible</b> applies.	85% after Calendar Year <b>deductible</b>	85% per visit after Calendar Year <b>deductible</b>
Spinal Manipulation Maximum visits per Calendar Year	30 visits	30 visits	30 visits

# Pharmacy Benefit

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Prescription Drug Calendar Year Deductible</b>		
Individual Deductible*	\$100	\$100
Family Deductible*		
Retiree + 1 Dependent Plan	\$200	\$200
Retiree + Family Plan	\$300	\$300

## Prescription Drug Calendar Year Deductible

The individual **prescription drug** Calendar Year **deductible** applies separately to you and each of your covered dependents. The family **prescription drug** Calendar Year **deductible** applies to you and your covered dependents combined. After **prescription drug covered expenses** reach the **prescription drug** Calendar Year **deductible**, the plan will begin to pay benefits for **prescription drug covered expenses** for the rest of the Calendar Year. The **prescription drug** Calendar Year **deductible** applies to **network** and **out-of-network prescription drug covered expenses** combined. The **prescription drug** Calendar Year **deductible** applies to **all prescription drug covered expenses** except, drugs dispensed by a **mail-order pharmacy**.

## Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
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*The following Generic Prescription Drugs information applies Effective October 1, 2015 through December 31, 2015:*

<b>Generic Prescription Drugs</b>		
For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable

*The following Generic Prescription Drugs information applies Effective January 1, 2016:*

### **Generic Prescription Drugs**

For each initial 30 day supply filled  
at a retail **pharmacy**

<b>Formulary Prescription Drugs</b>	20%	20%
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<b>Non Formulary Prescription Drugs</b>	30%	30%
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This applies to all refills after the  
second refill of a 30 day supply filled  
at a retail **pharmacy**

<b>Formulary Prescription Drugs</b>	50%	50%
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<b>Non Formulary Prescription Drugs</b>	50%	50%
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For all fills of a 90 day supply filled  
at a **mail order pharmacy** or a  
CVS/pharmacy

<b>Formulary Prescription Drugs</b>	20%	Not Applicable
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<b>Non Formulary Prescription Drugs</b>	30%	Not Applicable
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### **Preferred Brand-Name Prescription Drugs**

For each initial 30 day supply filled at a retail <b>pharmacy</b>	20%	20%
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This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
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For all fills of a 90 day supply filled at a <b>mail order pharmacy</b> or a CVS/pharmacy	20%	Not Applicable
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### **Non-Preferred Brand-Name Prescription Drugs**

For each initial 30 day supply filled at a retail <b>pharmacy</b>	30%	30%
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This applies to all refills after the second refill of a 30 day supply filled at a retail <b>pharmacy</b>	50%	50%
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For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order <b>pharmacy</b> or a CVS/pharmacy	30%	Not Applicable
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<b><i>Preferred Specialty Care Prescription Drug</i></b>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200
<b><i>Non-preferred Specialty Care Prescription Drugs</i></b>		
For each 30 day supply	20% of the <b>negotiated charge</b> not to exceed \$200	20% of the <b>recognized charge</b> not to exceed \$200

If you or your **prescriber** request a covered **brand-name prescription drug** when a covered **generic prescription drug** equivalent is available, you will be responsible for the cost difference between the **generic prescription drug** and the **brand-name prescription drug**, plus the applicable cost sharing.

### **Copay and Deductible Waiver**

#### **Waiver for Risk-Reducing Breast Cancer Prescription Drugs**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

#### **Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs**

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

#### **Waiver for Prescription Drug Contraceptives**

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
  - **brand-name prescription drugs** and devices and
  - FDA-approved female brand-name emergency contraceptives,
 that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>FDA-Approved Female Generic Over-the-Counter Contraceptives</b>  For each 30 day supply filled at a retail <b>pharmacy</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
<b>FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives</b>	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.

**Important Note:**

This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at [www.aetna.com](http://www.aetna.com) or calling the toll-free number on the back of the ID card.

***Preventive Care Drugs and Supplements***

Preventive care drugs and supplements filled at a <b>pharmacy</b> with a <b>prescription</b> :	100% per item.  No <b>copay</b> or <b>deductible</b> applies.	Not Covered.
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Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

**Important Note:**

Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

***Preventive Care Drugs and Supplements  
Continued***

***Tobacco Cessation Prescription and Over-the-Counter Drugs***

Tobacco cessation <b>prescription drugs</b> and OTC drugs filled at a <b>pharmacy</b> for each 90 day supply.	100% per supply  No <b>copay</b> or <b>deductible</b> applies.	Not covered.
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**Maximums:**

Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

**Coinsurance**

	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drug Plan Coinsurance</b>	100% of the <b>negotiated charge</b>	100% of the <b>recognized charge</b>

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

***The following Precertification and step therapy language applies effective January 1, 2016:***

**Precertification** and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

**Expense Provisions**

**The following provisions apply to your health expense plan.**

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

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

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

### **Deductible Provisions**

**Covered expenses** applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

### **Network Provider Calendar Year Deductible**

#### **Individual**

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

#### **Family Deductible Limit**

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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

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

### **Out-of-Network Provider Calendar Year Deductible**

#### **Individual**

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

#### **Family Deductible Limit**

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

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

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



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

### **Common Accident Out-of-Network Deductible Limit**

This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **out-of-network providers**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **out-of-network deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **out-of-network deductible** limit benefit amount paid for the same **covered expenses**.

## **Copayments and Benefit Deductible Provisions**

### **Copayment, Copay**

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.

### **Per Admission Copayment**

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount 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.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount. Not more than two per admission **copayments** per family will apply for each facility type during a Calendar Year.

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

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will be waived.

## **Payment Provisions**

### **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. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

### **Network Provider Maximum Out-of-Pocket Limit**

#### **Individual**

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### **Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

### **Out-of-Network Provider Maximum Out-of-Pocket Limit**

#### **Individual**

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

#### **Family Maximum Out-of-Pocket Limit**

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

**Covered expenses** that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

### **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**;
- Non-covered expenses;

- Any **covered expenses** which are payable by **Aetna** at 50%; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

### **Precertification Benefit Reduction**

The Booklet 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 reduced payment percentage of 20% will apply separately to the eligible expenses incurred for each type of service or supply.

### **General**

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

## Preface

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

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

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

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

<b>Employer:</b>	The Dow Chemical Company
<b>Contract Number:</b>	783135
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# 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.

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 *Booklet* for more information about your coverage.

## Treatment Outcomes of Covered Services

**Aetna** is not a provider of health care services and therefore is not responsible for and does 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.

# How Your Medical Plan Works

Common Terms

Accessing Providers

Precertification

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

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

## Important Notes

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

## Common Terms

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

## About Your Aetna Choice POS II Medical Plan

This Aetna Choice POS II medical plan provides coverage for a wide range of medical expenses for the treatment of **illness** or **injury**. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your Aetna Choice POS II plan, you can directly access any **network** or **out-of-network physician, hospital** or other health care provider 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** under this plan.

### Important Note

**Network providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members. **Network providers** are generally identified in the printed **directory** and the on-line version of the **directory** via DocFind at [www.aetna.com](http://www.aetna.com) unless otherwise noted in this section. **Out-of-network providers** are not listed in the **Aetna directory**.

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

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

This Aetna Choice POS II plan provides access to covered benefits through a broad network of health care providers and facilities. This Aetna Choice POS II 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 **network providers** and facilities.

You also have the choice to access licensed **providers**, **hospitals** and facilities outside the network for covered services and supplies. Your out-of-pocket costs will generally be higher when you use **out-of-network** providers because the **deductibles**, **copayments**, and **payment percentage** that you are required to pay 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 expenses** under this Booklet. If **Aetna** determines that the recommended services or supplies are not **covered expenses**, 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 Booklet.

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.

You will be subject to the **PCP** copay shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **Network Provider** unless such **PCP** is also an **Aexcel Designated Network** or **Non-Designated Network Specialist Physician**. In that case, the **Specialist** copay will apply.

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

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

A **PCP** coordinates your medical care, as appropriate either by providing treatment or may direct you to other **network providers** for other covered services and supplies. The **PCP** can also order lab tests and x-rays, prescribe medicines or therapies, and arrange **hospitalization**.

### Changing Your PCP

You may change your **PCP** at any time on **Aetna's** website, [www.aetna.com](http://www.aetna.com), or by calling the Member Services toll-free number on your identification card. The change will become effective upon **Aetna's** receipt and approval of the request.

### 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 Booklet. 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 Note

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

### Accessing Network Providers and Benefits

- You may select a **PCP** or other direct access **network provider** from the **network provider directory** or by logging on to **Aetna's** website at [www.aetna.com](http://www.aetna.com). You can search **Aetna's** online **directory**, DocFind, for names and locations of **physicians**, **hospitals** and **other health care** providers and facilities. You can change your **PCP** at anytime.
- If a service or supply you need is covered under this Plan but not available from a **network provider** in your area, your **PCP** may refer you to an **out-of-network provider**. As long as your **PCP** has provided you with a **referral** that has been approved by **Aetna**, you will receive the network benefit level as shown in your *Schedule of Benefits*.
- If a service or supply you need is covered under this Plan but not available from a **network provider 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 **precertify** services provided by a **network provider**. **Network providers** will be responsible for obtaining necessary **precertification** for you. Since **precertification** is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of a **network provider's** failure to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- Except for your **prescription drug** expenses, 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 may be required to pay some **network providers** at the time of service. When you pay a **network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Booklet for a complete description of how to file a claim under this Plan.
- 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*.**

When you or your eligible dependents become covered under this plan, you have access to a unique network of Primary Care Physicians, specialists and health care facilities. The Dow Chemical Company and Aetna Life Insurance Company (Aetna) have joined forces to create an expanded network of health care providers. In many cases, you will receive the Plan's maximum level of coverage when you receive care from a participating The Dow Chemical Company provider. These providers are referred to as Home Host Providers. If care is provided by a physician or facility in Aetna's network of providers, that care is also covered, but your copayment will be higher. Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

- **Network providers** have agreed to accept the **negotiated charge**. Aetna will reimburse you for a **covered expense**, incurred from a **network provider**, up to the **negotiated charge** and the maximum benefits under this Plan, less any cost sharing required by you such as **deductibles**, **copayments** and **payment percentage**. Your **payment percentage** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply.
- You must satisfy any applicable **deductibles** before the plan will begin to pay benefits.
- **Deductibles** and **payment percentage** are usually lower when you use **network providers** than when you use **out-of-network providers**.
- For certain types of services and supplies, you will be responsible for any **copayments** shown in your *Schedule of Benefits*. The **copayments** will vary depending upon the type of service and whether you obtain covered health care services from a provider who is a **specialist** or **non-specialist**. You will be subject to the **PCP copayments** shown on the *Schedule of Benefits* when you obtain covered health care services from any **PCP** who is a **network provider**. If the provider is also an **Aexcel designated network specialist** or **non-designated network specialist**, then the **specialist copayment** will apply.
- 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.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limits**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.
- You may be billed for any **deductible**, **copayment**, or **payment percentage** amounts, or any non-covered expenses that you incur.

## Accessing Out-of-Network Providers and Benefits

- Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require **precertification** with Aetna to verify coverage for these services. When you receive services from an **out-of-network provider**, you are responsible for obtaining the necessary **precertification** from Aetna. Your provider may **precertify** the services for you. However, you should verify with Aetna prior to the service, that the provider has obtained **precertification** from Aetna. If the service is not **precertified**, the benefit payable may be significantly reduced or may not be covered. This means you will be responsible for the unpaid balance of any bills. You must call the **precertification** toll-free number on your ID card to **precertify** services. Refer to the *Understanding Precertification* section for more information on the **precertification** process and what to do if your request for **precertification** is denied.
- When you use **out-of-network providers**, you may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to Aetna for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** that you paid directly to an **out-of-network provider**.

- When you pay an **out-of-network provider** directly, you will be responsible for completing a claim form to receive reimbursement of **covered expenses** from **Aetna**. You must submit a completed claim form and proof of payment to **Aetna**. Refer to the *General Provisions* section of this Booklet for a complete description of how to file a claim under this plan.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible**, or **payment percentage** amounts or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

#### **Important Note**

Failure to **precertify** services and supplies will result in a reduction of benefits or no coverage for the services or supplies under this Booklet. Please refer to the *Understanding Precertification* section for information on how to request **precertification**.

#### **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*.**

- **Out-of-network providers** have not agreed to accept the **negotiated charge**. **Aetna** will reimburse you for a **covered expense**, incurred from an **out-of network provider**, up to the **recognized charge** and the maximum benefits under this Plan, less any cost-sharing required by you such as **deductibles** and **payment percentage**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from an **out-of-network provider**. Your **payment percentage** is based on the **recognized charge**. If your **out-of-network provider** charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. Except for emergency services, **Aetna** will only pay up to the **recognized charge**.
- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- **Deductibles** and **payment percentage** are usually higher when you use **out-of network providers** than when you use **network providers**.
- 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 limits** that apply to your plan.
- Once you satisfy any applicable **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limits for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* for information on what **covered expenses** do not apply to the **maximum out-of-pocket limits** and for the specific **maximum out-of-pocket limit** amounts that apply to your plan.
- The plan will pay for **covered expenses**, up to the benefit maximums shown in the *What the Plan Covers* section or the *Schedule of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* section or the *Schedule of Benefits*.

**NOTE:** There are no Out-of-Network benefits at all at the facilities listed below, other than outpatient and inpatient emergency services. This means that there is no Out-of-Network coverage for both:

- health care services provided by the facility; and
  - health care services provided by physicians and other health care professionals at the facility.
- Houston Physicians Hospital
  - University General Hospital, LP
  - Oprex Surgery Houston LP
  - Houston MicroSurgery Institute
  - International Center for Surgical Science
  - First Street Hospital

- First Surgical Hospital
- Spars Surgical Center
- Houston Metro Ortho and Spine Surgery Ctr
- Kirby Surgical Center

For coverage of outpatient and inpatient emergency services by **Network** and **Out-of-Network providers**, Health Plan may require a member to submit medical records supporting the emergency medical condition. It is the member's responsibility to submit any requested medical records. One or more providers may submit any requested medical records on the member's behalf, but it remains the member's responsibility to ensure that all requested medical records are submitted. If the member (or providers on the member's behalf) does not submit all requested medical records, all claims for coverage of outpatient and inpatient emergency services will be denied.

In addition to the above facilities, your Dow Chemical medical plan will no longer pay for any services received at certain facilities.

These facilities are:

- The Houston Center for Outpatient Surgery
- Physicians Surgicenter of Houston
- St. Michaels Center for Special Surgery
- Center for Minimally Invasive Surgery, LLC

This means that there is no coverage for both:

- health care services provided by these facilities, and
- health care services provided by physicians and other health care professionals at these facilities.

If you use any of these facilities for any service you will be responsible for the full cost of services.

## 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 **precertify** 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 **precertify** 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 **precertify**, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring **precertification** follows on the next page.

### Important Note

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

### The Precertification Process

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

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

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

**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 Booklet.

## Services and Supplies Which Require Precertification

**Precertification** is required for the following types of medical expenses:

### Inpatient and Outpatient Care

- Stays in a **hospital**;
- Stays in a **skilled nursing facility**;
- Stays in a **rehabilitation facility**;
- Stays in a **hospice facility**;
- Outpatient **hospice care**;
- Stays in a **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;
- Applied Behavioral Analysis;

- 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 <b>precertification</b> is:	then the expenses are:
▪ requested and approved by <b>Aetna</b> .	▪ covered.
▪ requested and denied.	▪ not covered, may be appealed.
▪ not requested, but would have been covered if requested.	▪ covered after a <b>precertification</b> benefit reduction is applied.*
▪ not requested, would not have been covered if requested.	▪ 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 limit** 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.
- Except for the Home Host/IDS Out-of-Area MAP Plus Option 1 Plan, if you seek care in an Out-of-Network emergency room for a non-emergency condition, your benefits will be reduced. 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

Except for the Home Host/IDS Out-of-Area MAP Plus Option 1 Plan, if you visit an Out-of-Network **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, 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 **PCP** if you think you need urgent care. **Network providers** are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any **physician** or **urgent care provider**, in- or out-of-network, for an **urgent care condition** if you cannot reach your **physician**.

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

## Coverage for an Urgent Condition

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

## Non-Urgent Care

If you seek care from an **urgent care provider** for a non-urgent condition (one that does not meet the criteria above), your benefits will be reduced unless otherwise specified under the Plan. Please refer to the *Schedule of Benefits* for specific plan details.

### Important Reminder

If you visit an **urgent care provider** for a non-urgent condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-urgent care received at a hospital or an urgent care provider unless otherwise specified.

## 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**. Except for the Home Host/IDS Out-of-Area MAP Plus Option 1 Plan, if you access an Out-of-Network **hospital** emergency room for follow-up care, your coverage will be reduced and you will be responsible for more of the 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 and **prescription drugs** must meet all of the following requirements:

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

#### Important Notes:

1. The recommendations and guidelines of the:
  - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  - United States Preventive Services Task Force;
  - Health Resources and Services Administration; and
  - American Academy of Pediatric/Bright Futures Guidelines for Children and Adolescents.

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

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

### Routine Physical Exams

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents.

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial **hospital** check up.

#### **Limitations:**

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

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

### **Preventive Care Immunizations**

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

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

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

#### **Limitations**

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

### **Well Woman Preventive Visits**

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

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

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

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

#### **Limitations:**

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

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;

- Exams given during your **stay** for medical care;
- Services not given by a **physician** or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

## Routine Cancer Screenings

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

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

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

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

### Limitations:

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

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

### Important Notes:

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

## Screening and Counseling Services

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

### Obesity and/or Healthy Diet

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

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

### Misuse of Alcohol and/or Drugs

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

### **Use of Tobacco Products**

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

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

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

Covered expenses also include charges for drugs prescribed to alleviate the effects for nicotine withdrawal and nicotine replacement products including nicotine patches and gum.

### **Sexually Transmitted Infections**

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

### **Genetic Risks for Breast and Ovarian Cancer**

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

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

### **Limitations:**

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

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

### **Prenatal Care**

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height).

### **Limitations:**

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

- Services which are covered to any extent under any other part of this Plan;
- Pregnancy expenses (other than prenatal care as described above).

### **Important Notes:**

Refer to the *Pregnancy Expenses* and *Exclusions* sections of this Booklet for more information on coverage for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

## Comprehensive Lactation Support and Counseling Services

**Covered expenses** include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy, or at any time following delivery, for breast-feeding by a certified lactation support provider. **Covered expenses** also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are **covered expenses** when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in your *Schedule of Benefits*.

### Breast Feeding Durable Medical Equipment

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

#### Breast Pump

**Covered expenses** include the following:

- The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a **hospital**.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once per pregnancy.
- If an electric breast pump was purchased within the previous three year period, the purchase of another breast pump will not be covered until a three year period has elapsed from the last purchase.

#### Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

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

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

#### Limitations:

Unless specified above, not covered under this *Preventive Care* benefit are charges incurred for services which are covered to any extent under any other part of this Plan.

## Family Planning Services - Female Contraceptives

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

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

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

## Voluntary Sterilization

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

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

## Contraceptives

Contraceptives can be paid either under your medical plan or **pharmacy** plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive **prescription drugs** and devices (including any related services and supplies) when they are provided, administered, or removed, by a **physician** during an office visit.

### Important Note:

For a list of the types of female contraceptives covered under this Plan, refer to the section *What the Pharmacy Plan Covers* and the *Contraceptives* benefit later in this Booklet.

## Limitations:

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

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

## Family Planning Services - Other

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

- Voluntary sterilization for males
- Voluntary termination of pregnancy

## Limitations:

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by your employer; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

### Important Notes:

Refer to the Schedule of Benefits for details about cost sharing and benefit maximums that apply to Family Planning Services - Other. For more information, see the sections on Family Planning Services - Female Contraceptives, Pregnancy Expenses and Treatment of Infertility in this Booklet.

## Vision Care Services

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

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

## Limitations

Coverage is subject to any applicable Calendar Year **deductibles**, **copays** and **payment** percentages 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;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you:
  - to stop the use of tobacco products;
  - in weight reduction due to obesity.

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

- In a group setting for screening and counseling services.

**Important Note:**

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

**E-Visits**

**Covered expenses** include charges made by your **physician** for a routine, non-emergency, medical consultation. You must make your **E-visit** through an **Aetna** authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on [www.Aetna.com](http://www.Aetna.com) or by calling the number on your identification card.

## 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 **precertified** 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 **PCP** after receiving treatment for an **emergency medical condition**.

### Important Reminder\*

With the exception of Urgent Care described below, if you visit an Out-of-Network **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

\*This does not apply to the Home Host/IDS Out-of-Area MAP Plus Option 1 Plan.

## 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 Note

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

The following outpatient surgery expenses are covered:

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

### Limitations

Not covered under this plan are charges made for:

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

## Birthing Center

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

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

### Limitations

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

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

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

## Home Health Care

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

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- 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 a **hospital stay**.
- Skilled behavioral health care services provided in the home by a **behavioral health provider** when ordered by a **physician** and directly related to an active treatment plan of care established by the **physician**. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, **illness** or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a **hospital** or **residential treatment facility**, or receiving outpatient services outside of the home.
  - You are **homebound** because of **illness** or **injury**.
  - The services provided are not primarily for comfort or convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

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

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

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

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

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

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

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

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

## Limitations

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

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

## 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.

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

## Skilled Nursing Care

**Covered expenses** include charges by an **R.N.**, **L.P.N.**, or nursing agency for outpatient skilled nursing care.

This is care by a visiting **R.N.** or **L.P.N.** to perform specific skilled nursing tasks.

**Covered expenses** also include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any expenses during a Calendar Year in excess of the Private Duty Nursing Care Calendar Year Maximum.

## Limitations

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

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

## Skilled Nursing Facility

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

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

### 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 **precertified** 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**.
- 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.

### 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 **precertified** by **Aetna**. Refer to *How the Plan Works* for details about **precertification**.

## Other Covered Health Care Expenses

### Acupuncture

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

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

### Important Reminder

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

## Ambulance Service

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

### Ground Ambulance

**Covered expenses** include charges for transportation:

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

### Air or Water Ambulance

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

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

### Limitations

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

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service; or
- By fixed wing air ambulance from an **out-of-network provider**.

## Diagnostic and Preoperative Testing

### Diagnostic Complex Imaging Expenses

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

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medicine imaging including positron emission tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service where the **recognized charge** exceeds \$500.

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

### Limitations

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

## Outpatient Diagnostic Lab Work

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

## Important Reminder

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

## Clinical Trials

### *Clinical Trial Therapies (Experimental or Investigational)*

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

- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

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

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

### *Routine Patient Costs*

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

#### **Limitations:**

Not covered under this Plan are:

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

#### **Important Note:**

1. Refer to the *Schedule of Benefits* for details about cost sharing and any benefit maximums that apply to the Clinical Trial benefit.
2. These Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations, and exclusions of this Plan including, but not limited to, any precertification and referral requirements.

## **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.

#### **Important Note:**

Refer to the *Preventive Care* section of this *Booklet* for additional information on coverage for female contraceptive coverage under this Plan.

# 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;
- Foot orthotics and supportive devices of the feet; and
- A durable brace that is custom made for and fitted for you.

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

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

## Treatment of Autism Expense

**Covered expenses** include expenses incurred by a **covered person** under 18 years of age for services for the diagnosis and treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders. Benefits are payable in the same way as those for any other disease.

**Pervasive Developmental Disorders**/Autism Spectrum Disorders means:

- A developmental neurological disorder, appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

## Applied Behavioral Analysis

**Covered expenses** include expenses incurred by a **covered person** under 18 years of age for Applied Behavioral Analysis for treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders and other behavioral health conditions, as prescribed by a **physician**. Benefits are payable in the same way as those for any other disease.

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

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

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable copays, deductibles, coinsurance, and benefit maximums.

## 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 Rehabilitation Benefits

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

- 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

- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

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

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

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function. Coverage for physical therapy is available for the treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders/developmental delays (as an exception to the above non-chronic condition coverage criteria) for a **covered person** under age 18.
- 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. Coverage for occupational therapy is available for the treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders/developmental delays (as an exception to the above non-chronic condition coverage criteria) for a **covered person** under age 18.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries provided the therapy is expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Coverage for speech therapy is available for the treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders/developmental delays (as an exception to the above non-chronic condition coverage criteria) for a **covered person** under age 18.
- 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:

- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services for the treatment of delays in speech development, unless resulting from **illness, injury**, or congenital defect;
- Services provided during a **stay** in a **hospital, skilled nursing facility**, or **hospice facility** except as stated above;
- Services provided by a **home health care agency**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;

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

## Reconstructive or Cosmetic Surgery and Supplies

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

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, 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 infusion therapy received from an outpatient setting including but not limited to:

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

The list of preferred infusion locations can be found by contacting Member Services by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this booklet.

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

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

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

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

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

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

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

#### **Important Reminder**

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** and maximum benefit limits.

## **Specialty Care Prescription Drugs**

**Covered expenses** include **specialty care prescription drugs** when they are:

- Purchased by your **provider**, and
- Injected or infused by your **provider** in an outpatient setting such as:
  - A free-standing outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in his/her office
  - A home care **provider** in your home
- And, listed on our **specialty care prescription drug** list as covered under this booklet.

Certain infused medications may be covered under the **prescription drug** plan. You can access the list of **specialty care prescription drugs** by contacting Member Services or by logging onto your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com) or calling the number on the back of your ID card to determine if coverage is under the **prescription drug** plan of this booklet.

## Kidney Disease Treatment

Covered expenses include charges incurred by a covered person for dialysis for the treatment of kidney disease.

No benefits will be paid for charges made for:

- Treatments which are not ordered by the covered person's attending physician.
- Treatments received at a place which is not approved by the covered person's attending physician.
- Physician's expenses.

### Important Reminder

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

## Diabetic Education

**Covered expenses** include charges for Self-management training provided by a licensed health care provider certified in diabetes self-management training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

## 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**.

### Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

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

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

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



## Comprehensive Infertility Services Benefits

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

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

\*The maximum of 6 attempts per lifetime is a combined lifetime maximum, which includes ovulation induction and intrauterine insemination.

## Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

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

## Eligibility for ART Benefits

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

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your **physician** to Aetna's infertility case management unit;
- Obtain pre-authorization from Aetna's infertility case management unit for ART services by an ART specialist.

## Covered ART Benefits

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

- Up to 3 cycles and subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by **Aetna** or any affiliated company of **Aetna**) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the *Schedule of Benefits* section while covered under an **Aetna** plan;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this *Booklet*.

## Exclusions and Limitations

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

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

### Important Note

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

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

## Fertility Preservation Benefits for Cancer Patients Only

**Eligibility:** To be eligible:

- you or your partner has a diagnosis of cancer and you are planning cancer treatment that is demonstrated to result in infertility. Planned cancer treatments include:
  - bilateral orchiectomy (removal of both testicles);
  - bilateral oophorectomy (removal of both ovaries);
  - hysterectomy (removal of the uterus);
  - chemotherapy or radiation therapy that is established in medical literature to result in infertility; and
- you are a female:
  - *who is under 35 years of age* and had a day 3 FSH test in the prior 12 months; or
  - *who is 35 years of age or older* and had a day 3 FSH test in the prior 6 months,with a result that is less than 19 mIU/ml in any (past or current) menstrual cycle regardless of the type of infertility services planned which may include donor egg, donor embryo or frozen embryo cycle.

**Fertility Preservation Benefits for Cancer Patients Only:** Covered **expenses** include only those **ART Services** that have a reasonable likelihood of success. Therefore, you must obtain **precertification** through **Aetna's Infertility Case Management Unit**, either directly or through a reproductive endocrinologist.

**Covered expenses** for fertility preservation will be paid on the same basis as **ART Services** benefits for individuals who are **infertile** and not diagnosed with cancer.

## 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 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).

Benefits are payable up to the Non-surgical **jaw joint disorder** lifetime maximum shown in the *Schedule of Benefits*.

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

## Transplant Services

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

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

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

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;

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

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

Services 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 **precertified** by **Aetna**. Refer to the *How the Plan Works* section for details about **precertification**.

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

## Limitations

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

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- 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.

## Obesity Treatment

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

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

### Morbid Obesity Surgical Expenses

Covered medical expenses include charges made by a **hospital** or a **physician** for the surgical treatment of morbid obesity of a covered person.

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One morbid obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits;
- Related outpatient services; and
- One follow-up visit.

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

## Limitations

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

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

### Important Reminder

Refer to the *Schedule of Benefits* for information about any applicable benefit maximums that apply to **morbid obesity** treatment.

## Treatment of Mental Disorders and Substance Abuse

### Treatment of Mental Disorders

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

### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Plan Exclusions* for more information.

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.

### Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

### 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.

### Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

### Outpatient Treatment

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

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

Outpatient mental health treatment also includes:

- Electro-convulsive therapy (ECT); and

- Substance use disorder injectables.

#### Important Reminder

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums, **payment limits** or **maximum out of pocket limits** that may apply to your **mental disorders** benefits.

## Treatment of Substance Abuse

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

#### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Medical Plan Exclusions* for more information.

### Substance Abuse

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

### Inpatient Treatment

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

Coverage includes:

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

#### Important Reminder

Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

### Outpatient Treatment

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

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

#### Important Reminder

Inpatient treatment, partial-**hospitalization** care and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.

### Partial Confinement Treatment

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

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

### Important Reminders:

- Inpatient care, partial **hospitalizations** and outpatient treatment must be **precertified** by **Aetna**. Refer to *How the Plan Works* for more information about **precertification**.
- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums, **payment limits** or **maximum out-of-pocket limits** that may apply to your **substance abuse** benefits.

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

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

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

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

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when **not** done in connection with the removal, replacement or repair of teeth. Dental implant surgery, however, may be covered when medically necessary.
- 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 Booklet.

## **Important Note:**

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

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

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (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 Booklet.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs** or supplies, even if otherwise covered under this Booklet. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

## **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 Booklet.

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**.

Charges for a service or supply furnished by 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.

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

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, except as covered for diabetic supplies;
- 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**, injectables, or medications or supplies provided by the customer or through a third party vendor contract with the customer; and
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services (except in the form of **Applied Behavioral Analysis** as provided for the treatment of **Pervasive Developmental Disorders**/Autism Spectrum Disorders for a covered person under age 18 and other behavioral health conditions, as prescribed by a **physician**):

- 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, learning disorders, behavioral 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.

Note: This exclusion does not apply to training directly related to the care of a medical (non-behavioral) condition such as learning to change a dressing or care for a colostomy.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

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

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

Facility charges for care services or supplies provided in:

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

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

Foot care: 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), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

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

Hearing:

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

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

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

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

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

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;

- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

### **Maintenance Care.**

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

Miscellaneous charges for services or supplies including:

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

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

Non-**medically necessary** services, including but not limited to, those treatments, services, **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: coverage is excluded for 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 Booklet.

Services that are not covered under this Booklet.

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

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

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body 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; except in the form of Applied Behavioral Analysis as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders for a covered person under age 18 and other behavioral health conditions, as prescribed by a physician;
- 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;
- 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 **precertified** by **Aetna**.

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

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

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

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

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

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

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

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



# Your Pharmacy Benefit

## How the Pharmacy Plan Works

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

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

### A few important notes to consider before moving forward:

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

### Notice

The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- **Injectable prescription drug** refills will only be covered when obtained through **Aetna’s specialty pharmacy network**.

## Getting Started: Common Terms

You will find the terms below used throughout this Booklet. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

**Brand-Named Prescription Drug** is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

**Generic Prescription Drug** is a **prescription drug**, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Medispan or any other publication designated by **Aetna**.

**Network pharmacy** is a description of a retail, **mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

**Non-Preferred Drug (Non-Formulary)** is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

**Out-of-network pharmacy** is a description of a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor and does not participate in the pharmacy network.

**Preferred Drug (Formulary)** is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

**Preferred Drug Guide** is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at [www.aetna.com/formulary](http://www.aetna.com/formulary).

**Prescription Drug** is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

Provider is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

**Self-injectable Drug(s)**. Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

## Accessing Pharmacies and Benefits

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

### Accessing Network Pharmacies and Benefits

You may select a **network pharmacy** from Aetna’s on-line provider directory which can be found at [www.aetna.com](http://www.aetna.com). You can search Aetna’s online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area, call Member Services at the number on your ID card.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for **network pharmacy benefits**. The **network pharmacy** will calculate your claim online. You will pay any **deductible**, **copayment** or **coinsurance** directly to the **network pharmacy**. You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

### Emergency Prescriptions

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain **network pharmacy** benefits by filling your **prescription** at any **network pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan’s cost sharing amount.

If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network pharmacy** benefits.

## Availability of Providers

**Aetna** cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

## 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.
- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you satisfy any applicable **deductible** and pay the applicable **copayment**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur. Your **payment percentage** is determined by applying the applicable **payment** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

## When You Use an Out-of-Network Pharmacy

You can directly access an out-of-network **pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. The Plan will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

## 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 calendar year **deductibles** before the plan will begin to pay benefits.
- After you satisfy any applicable year **deductible(s)**, you will be responsible for any applicable payment percentage for **covered expenses** that you incur. Your payment percentage share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

## Pharmacy Benefit

### What the Plan Covers

The plan covers charges for **medically necessary** outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the *Prescription Drug Limitations* section below and the *Exclusions* section of the *Booklet*. **Prescriptions** must be written by a **prescriber** licensed to prescribe federal legend **prescription drugs**.

Your prescription drug benefit coverage is based on **Aetna's preferred drug guide**. Your out-of-pocket expenses may be higher if your **physician** prescribes a covered **prescription drug** not appearing on the **preferred drug guide**.

**Preferred generic prescription drugs** may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

*The following paragraph is effective from October 1, 2015 through December 31, 2015:*

Coverage of **prescription drugs** may, in Aetna's sole discretion, be subject to Aetna requirements or limitations. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by Aetna, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for **covered expenses**.

*Effective January 1, 2016, the following paragraph replaces the above paragraph:*

Coverage of **prescription drugs** may, in Aetna's sole discretion, be subject to **precertification, step therapy** or other Aetna requirements or limitations. **Prescription drugs** covered by this plan are subject to drug and narcotic utilization review by Aetna, your **provider** and/or your **network pharmacy**. This may include limiting access of **prescription drugs prescribed** by a specific **provider**. Such limitation may be enforced in the event that Aetna identifies an unusual pattern of claims for **covered expenses**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

### **Retail Pharmacy Benefits**

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

### **Mail Order Pharmacy Benefits**

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy** and a CVS/pharmacy®. Each **prescription** is limited to a maximum 90 day supply. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

All **prescription** refills after the second refill at a **network retail pharmacy** must be filled at a **network mail-order pharmacy** or a CVS/pharmacy. The **negotiated charge** will be the same for **prescriptions** obtained at a CVS/pharmacy or at a **network mail-order pharmacy**. If you continue to use a **network retail pharmacy** after your second refill, your cost sharing will be increased as shown in the *Schedule of Benefits* below.

The plan will not cover outpatient **prescription drugs** received through an **out-of-network mail-order pharmacy**.

### **Network Benefits for Specialty Care Drugs**

**Specialty care drugs** are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or Aetna's **specialty pharmacy network pharmacy**. **Specialty care drugs** often include typically high-cost drugs that require special handling, special storage or monitoring and include but are not limited to oral, topical, inhaled and injected routes of administration. Refer to Aetna's website, [www.aetna.com](http://www.aetna.com) to review the list of **specialty care drugs** required to be dispensed through a **network pharmacy** or **specialty pharmacy network pharmacy**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at Aetna's **specialty pharmacy network**.

You are required to obtain **specialty care drugs** at Aetna's **specialty pharmacy network** for all prescription drug refills after the initial fill.

## Other Covered Expenses

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

*The following Off-Label Use sub-section is effective from October 1, 2015 through December 31, 2015:*

### Off-Label Use

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **Aetna** requirements or limitations.

*Effective January 1, 2016, the following Off-Label Use sub-section replaces the above sub-section of the same name:*

### Off-Label Use

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **precertification, step-therapy** or other **Aetna** requirements or limitations.

## Diabetic Supplies

Covered expenses include but are not limited to the following diabetic supplies upon **prescription** by a **physician**:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

## Contraceptives

**Covered expenses** include charges made by a network **pharmacy** for the following contraceptive methods when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing:

- Female oral and injectable contraceptives that are **generic prescription drugs** and **brand-name prescription drugs**.
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives; and.
- FDA-approved female generic over-the-counter (OTC) contraceptives.

### Important Note:

This Plan does not cover all contraceptives. For a current listing, contact Member Services by logging onto the Aetna website at [www.aetna.com](http://www.aetna.com) or calling the toll-free number on the back of the ID card.

Contraceptives can be paid either under your medical plan or pharmacy plan depending on the type of expense and how and where the expense is incurred. Benefits are paid under your medical plan for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.

Refer to the *Copay and Deductible Waiver* section of your *Schedule of Benefits* for cost-sharing information.

### Important Notes:

1. The Copay and Deductible Waiver does not apply to contraceptive methods that are:
  - **brand-name prescription drugs;**
  - FDA-approved female brand-name emergency contraceptives.
  - FDA-approved female brand-name over-the-counter (OTC) contraceptives.

However, the Copay and Deductible Waiver does apply when:

- such contraceptive methods are not available within the same **therapeutic drug class**; or
  - a generic equivalent, or generic alternative, within the same **therapeutic drug class** is not available; and
  - you are granted a medical exception. Refer to *Medical Exceptions* in the *Precertification* section for information on how you or your **prescriber** can obtain a medical exception.
2. A *generic equivalent* contains the identical amounts of the same active ingredients as the **brand-name prescription drug** or device. A *generic alternative* is used for the same purpose, but can have different ingredients or different amounts of ingredients.

### Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

### Lifestyle/Performance Drugs

The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.

***The following bulleted item applies from October 1, 2015 through December 31, 2015:***

- Mail order and 60 to 90 day supplies are not covered.

***Effective January 1, 2016, the following bulleted item replaces the above bullet:***

- Coverage is limited to 8 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

***The following Over-the counter drugs sub-section is effective as of January 1, 2016:***

### Over-the counter drugs

Over-the-counter medications, as determined by the plan may be covered in an equivalent prescription dosage strength for the appropriate member responsibility. Coverage of the selected over-the-counter medications requires a **prescription**. You can access the list by logging onto [www.aetna.com](http://www.aetna.com).

## Preventive Care Drugs and Supplements

**Covered expenses** include preventive care drugs and supplements (including over-the-counter drugs and supplements) obtained at a **network pharmacy**. They are covered when they are:

- prescribed by a **physician**;
- obtained at a **pharmacy**; and
- submitted to a pharmacist for processing.

The preventive care drugs and supplements covered under this Plan include, but may not be limited to:

- Aspirin: Benefits are available to adults.
- Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
- Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
- Iron Supplements: Benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
- Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
- Risk-Reducing Breast Cancer **Prescription Drugs**: Covered medical expenses include charges incurred for generic **prescription drugs** prescribed by a **physician** for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.

Coverage of preventive care drugs and supplements will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.

### Important Note:

For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your **physician** or Member Services by logging onto the Aetna website [www.aetna.com](http://www.aetna.com) and Aetna Navigator, or calling the number on the back of your ID card.

## Tobacco Cessation Prescription and Over-the-Counter Drugs

**Covered expenses** include FDA-approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the **prescription** is submitted to the pharmacist for processing.

Refer to the *Schedule of Benefits* for the cost-sharing and supply limits that apply to these benefits.

*The following Precertification and Step Therapy sub-sections are effective as of January 1, 2016:*

### Precertification

**Precertification** is required for certain outpatient **prescription drugs**. **Prescribers** must contact **Aetna** to request and obtain coverage for such **prescription drugs**. The list of drugs requiring **precertification** is subject to periodic review and change by **Aetna**. For the most up to date information, call the toll-free number on your member ID card or log on to your Aetna Navigator secure member website at [www.aetna.com](http://www.aetna.com).

Benefits will be reduced or denied if **Aetna** does not **precertify** your **prescription drug**. So ask your **prescriber** or pharmacist if your **prescription drug** needs to be **precertified**.

### How to Obtain Precertification

If an outpatient **prescription drug** requires **precertification** and you use a **network pharmacy** the **prescriber** is required to obtain **precertification** for you.

When you use an **out-of-network pharmacy**, you can begin the **precertification** process by having the **prescriber** call **Aetna** at the number on your ID card.

**Aetna** will let your **prescriber** know if the **prescription drug** is **precertified**.

If **precertification** is denied **Aetna** will notify you how the decision can be appealed.

## Step Therapy

**Step therapy** is a type of **precertification**. With **step therapy**, some **prescription drugs** will not be covered until you try one or more “prerequisite therapy” **prescription drugs**. Your **prescriber** can ask for a medical exception which is detailed below.

The plan will not cover the **step therapy** drug if you do not try a prerequisite therapy **prescription drug** first or if your **prescriber** does not get a medical exception.

**Step therapy** and prerequisite therapy **prescription drugs** are on the **Aetna preferred drug guide** available upon request or on your Aetna Navigator secure member website at [www.aetna.com](http://www.aetna.com). The list of **step therapy** drugs are subject to change by **Aetna**.

## Medical Exceptions:

Your **prescriber** may seek a medical exception to obtain coverage for drugs for which coverage is denied through **Precertification** or **Step Therapy**. You or your **prescriber** must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case **medical necessity** determination and coverage will not apply or extend to other covered persons.

## Pharmacy Benefit Limitations

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

**Aetna** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet.

**Aetna** reserves the right to include only one manufacturer’s product on the **preferred drug list** when the same or similar drug (that, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

**Aetna** reserves the right to include only one dosage or form of a drug on the **preferred drug list** when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed on our **preferred drug list** will be covered at the applicable **copayment** or **coinsurance**.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Some **prescription drugs** are subject to quantity limits. These quantity limits help your **prescriber** and pharmacist check that your **prescription drug** is used correctly and safely. **Aetna** relies on medical guidelines, FDA-approved recommendations from drug makers and other criteria developed by **Aetna** to set these quantity limits. The quantity limit may restrict either the amount dispensed per **prescription** order or refill.



Depending on the form and packing of the product, some **prescription drugs** are limited to a single commercially prepackaged item excluding insulin, diabetic supplies, test strips dispensed per **prescription** order or refill.

Depending on the form and packing of the product, some **prescription drugs** are limited to 100 units excluding insulin dispensed per **prescription** order or refill.

Any **prescription drug** that has duration of action extending beyond one (1) month shall require the number of **copayments** per prescribing unit that is equal to the anticipated duration of the medication. For example, a single injection of a drug that is effective for three (3) months would require three (3) **copayments**.

**Specialty care prescription drugs** may have limited access or distribution and are subject to supply limits.

Plan approved blood glucose meters, asthma holding chambers and peak flow meters are **eligible health services**, but are limited to one (1) **prescription** order per **contract year**.

## Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dentist** it may not be covered. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this *Booklet*. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage.

The plan does not cover the following expenses:

Abortion drugs.

Administration or injection of any drug.

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

Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this *Booklet*. This also includes **prescription drugs** or supplies if:

- Such drugs or supplies are unavailable or illegal in the United States, or
- The purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

#### Contraception:

- Over the counter contraceptive supplies including but not limited to:
  - condoms;
  - contraceptive foams;
  - jellies; and
  - ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

**Cosmetic** drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth or removal, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams;
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

#### Compounded **prescriptions**.

Devices and appliances that do not have the National Drug Code (NDC).

Dietary supplements including medical foods.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs for which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient.

Drugs which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written (except as specifically covered in the *What the Pharmacy Plan Covers* section).

Drugs provided by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs that include vitamins and minerals, both over-the counter (OTC) and legend, except legend pre-natal vitamins for pregnant or nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium and legend vitamins that are medically necessary for the treatment of renal disease, hyperparathyroidism or other covered conditions with prior approval from us unless recommended by the United States Preventive Services Task Force (USPSTF).

Drugs used for methadone maintenance medications used for drug detoxification.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and
- other medications.

Drugs used for the treatment of obesity.

All drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies.

Drugs or medications that include the same active ingredient or a modified version of an active ingredient.

Drug or medication that is therapeutically equivalent or therapeutically alternative to a covered **prescription drug**.

Drug or medication that is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product.

Duplicative drug therapy (e.g. two antihistamine drugs).

**Durable medical equipment**, monitors and other equipment.

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

This exclusion will **not** apply with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

Food items: Any food item, including:

- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

Immunization or immunological agents.

Implantable drugs and associated devices.

Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by the Plan;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the **specialty pharmacy network** is available upon request. You may also get a copy of the list on **Aetna's** website at [www.aetna.com](http://www.aetna.com).
- For any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

**Prescription drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

**Prescription drugs**, medications, injectables or supplies provided through a third party vendor contract with the contractholder.

**Prescription drugs** dispensed by a **mail order pharmacy** that include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.

**Prescription drugs** that include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the plan.

**Prescription drugs** that are ordered by a **dentist** or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription drugs** for the treatment of a dental condition.

**Prescription drugs** that are **non-preferred drugs**, unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

**Prescription drugs** that are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary**, or otherwise improper; and drugs obtained for use by anyone other than the member identified on the ID card.

**Prescription** orders filled prior to the effective date or after the termination date of coverage under this Booklet.

Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Drugs, services and supplies given in connection with treatment of an **occupational injury or occupational illness**.

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. This includes medications, nicotine patches and gum.

Strength and performance: Drugs or preparations, devices or supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.

Test agents except diabetic test agents.

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

## Other Plans Not Including Medicare

### COB if You Are Less than 65 Years of Age

When your Spouse of Record/Domestic Partner of Record is enrolled for medical coverage through his or her non Dow affiliated employer or former employer and under the Dow Plan, benefit payments will be coordinated with your Dow Plan. This means that claims may be filed to collect from both plans, but total benefits paid by Dow cannot exceed the negotiated fee schedule for services received through a Network provider or ***Recognized Charge*** for services received through an Out-of-Network or Out-of-Area provider. Note that dual coverage usually does NOT provide 100% coverage.

### Primary versus Secondary Plan

When two different group plans provide coverage for you and your family members, the plan which is primary pays benefits first. The plan which is secondary determines benefits available after payment by the primary plan. The chart below shows how it works. This chart does not apply to Coordination of Benefits with Medicare. See "COB with Medicare" chart.

When the patient is:	Your Dow Plan will be:	The other group plan will be:
The Dow Retiree*: (without new employment)	Primary	Secondary**
The Dow Retiree*: (actively at work elsewhere with benefits)	Secondary	Primary
A non-Dow Spouse of Record / Domestic Partner of Record	Secondary	Primary
A Dependent child, and the parent whose birthday falls earlier in the year is the Dow Retiree*:	Primary	Secondary**
A Dependent child, and the parent whose birthday falls later in the year is the Dow Retiree*:	Secondary	Primary
* or 60 Point or 65 Point Retiree Medical Severance Plan Participant		
** When the other group plan does not include a Coordination of Benefits provision, the other plan is always primary. Court rulings may supersede the order of benefits determination.		
If you are in an automobile accident, your automobile insurance will be the primary plan for your medical expenses resulting from the accident.		

## Dow as the Secondary Plan (not Applicable to COB with Medicare)

The following rules apply when the Dow Plan provides secondary coverage:

- Dow pays based on the balance remaining following payment by the primary plan, using all Dow benefits provisions.
- If payment by the primary plan is equal to or greater than either Dow's **negotiated charge** (if services were received through a Network provider) or the **recognized charge** (if services were received through an Out-of-Network or Out-of-Area provider), no benefits will be payable by the Dow Plans.
- Dow does not reimburse for expenses not covered by the Dow Plans.
- If your Spouse of Record's/Domestic Partner of Record's non Dow employer offers a choice of plans, *the Dow Plan benefits will be coordinated with those of the plan that is most comparable to the Dow Plan, regardless of the non Dow plan in which your Spouse of Record/Domestic Partner of Record is actually enrolled.*
- If your Spouse of Record's/Domestic Partner of Record's plan is a health maintenance organization (HMO) and a service normally provided by the HMO is received from a provider not affiliated with the HMO, no benefits will be payable under the Dow Plan. Each HMO has its own coordination of benefits guidelines. Please refer to the HMO for details. Generally, HMOs will only coordinate benefits with other HMOs if Network providers are used and the other HMO's rules have been followed.
- If your Spouse of Record's/Domestic Partner of Record's plan has special requirements, including but not limited to, mandatory second surgical opinions, use of Network Providers, outpatient surgery for certain procedures, precertification of hospital admissions or pre admission testing, the Dow Plan will not cover any expenses resulting from failure to comply with those requirements.
- Dual coverage usually does not provide 100% coverage.

Periodically, you may be requested to provide coordination of benefits information including, but not limited to, whether your Spouse of Record/Domestic Partner of Record works, details about the coverage available as a result of that employment and specific coverage information. The Plan may withhold Plan benefits if you or your Dependents fail to produce the required information.

# When You Have Medicare Coverage

## Effect of Medicare

### COB with Medicare Parts A & B

When Medicare is involved, Coordination of Benefits is more complex. The Dow Plans coordinate benefits with Medicare Parts A and B. They do NOT coordinate with Medicare Part D. To determine which plan pays first, second and third, refer to the following chart:

	Your Dow Plan will pay:	The other group plan will pay:	Medicare will pay:
If you are the patient and you and your non Dow Spouse of Record/Domestic Partner of Record are both retired and Enrolled in Medicare:	2nd	3rd	1st
If your non Dow Spouse of Record/Domestic Partner of Record is the patient and you and your Spouse of Record/Domestic Partner of Record are both retired and enrolled in Medicare:	3rd	2nd	1st
If you are the patient and you are retired and enrolled in Medicare, and your non Dow Spouse of Record/Domestic Partner of Record is an active employee:	3rd	1st	2nd
If you are retired and your non Dow Spouse of Record/Domestic Partner of Record is the patient and is an active employee enrolled in Medicare:	3rd	1st	2nd

These are the guidelines for Coordination of Benefits when Medicare is involved:

**Note:** If you use a provider who has opted out of, dis-enrolled from, or is non participating with Medicare, we will assume that Medicare benefits exist. Your Dow Plan will reduce the benefits by the amount that would have been paid by Medicare had the provider not opted out of, or dis-enrolled from Medicare.



**If you are age 65 or older enrolled in Medicare Parts A and B,** Medicare is the primary plan. Your Dow Plan is secondary, paying based on the Dow coverage level and the Plan Allowable Amount.

Submit your claims first to Medicare, then send your Medicare worksheet, along with a copy of the bill, to your claims administrator. This will be done electronically for you in many cases. Your Dow Plan will compute the normal benefit and reduce it by the amount paid by Medicare.

**If your Spouse of Record/Domestic Partner of Record is age 65 or older and is a full time employee of another company,** he or she will have primary coverage through the other employer's plan. If you are age 65 or older, Retired, and covered as a Dependent under your Spouse of Record's/Domestic Partner of Record's plan, that plan will be primary. For more information about coverage for employed Spouses of Record/Domestic Partners of Record, contact your medical claims administrator.

**If your Spouse of Record/Domestic Partner of Record is age 65 or older and is a retiree of another company,** he or she should not cancel coverage under the other employer's plan. The Dow Plan will not provide coverage unless your Spouse of Record/Domestic Partner of Record is enrolled in the other employer's plan. In this case Medicare will pay benefits first for your Spouse of Record/Domestic Partner of Record, the other employer's plan will pay second, and the Dow Plan will pay third on his or her eligible expense.

### **COB with Automobile Insurance**

Sometimes a Participant or Dependent is entitled to health care benefits through automobile insurance. Should this type of situation occur, the benefits under your Dow Plans will be coordinated so that the total benefits from all plans do not exceed the **negotiated charge** (for Network services) or the **recognized charge** (for Out-of-Network services). Your Dow Plan will be secondary to the auto insurance carrier.

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

### Financial Sanctions Exclusions

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

## Assignments

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

## Misstatements

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

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

## Rescission of Coverage

**Aetna** may rescind your coverage if you, or the person seeking coverage on your behalf:

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

You will be given 30 days advance written notice of any rescission of coverage.

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

## Reporting of Claims

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

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

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed later than the end of the calendar year following the year the eligible expenses were incurred.

## 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](http://www.aetna.com).

## Effect of Benefits Under Other Plans

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

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care, if any,) on the date of your coverage under such HMO Plan.

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

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

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

# Discount Programs

## Discount Arrangements

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and 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.

## Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment, payment percentage**, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

## Claims, Appeals and External Review

### Filing Health Claims under the Plan

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

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

### Urgent Care Claims

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

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

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

### **Other Claims (Pre-Service and Post-Service)**

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

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

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

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

### **Ongoing Course of Treatment**

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

### **Health Claims – Standard Appeals**

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

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

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

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

### **Exhaustion of Internal Appeals Process**

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

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

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

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

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

### **Full and Fair Review of Claim Determinations and Appeals**

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

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

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

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

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

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

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

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

## **Health Claims – Voluntary Appeals**

### **External Review**

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

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

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

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

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

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

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

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

### **Request for External Review**

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

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

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



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

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

### **Preliminary Review**

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

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

### **Referral to ERO**

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

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

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

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

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

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

### **Expedited External Review**

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

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

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

### **Referral of Expedited Review to ERO**

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

# Glossary

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet.

## A

### Aetna

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

### Aexcel Designated Network Specialists *(Applies to MAP Plus Aexcel Plan participants only)*

**Network providers** who have met designation criteria for thresholds of performance and effectiveness, as established by **Aetna**. They will be shown in the provider **directory** and on DocFind® as **Aexcel Designated Network Specialists** for the **specialty care** involved for the class of employees of which you are a member.

### Ambulance

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

### Average Wholesale Price (AWP)

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

## B

### Behavioral Health Provider/Practitioner

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

### Birthing Center

A freestanding facility that meets *all* of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.

- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

## Body Mass Index

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

## Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

## C

### Copay or Copayment

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

### Cosmetic

Services or supplies that alter, improve or enhance appearance.

### Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

### Creditable Coverage

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

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-CHIP).

## Custodial Care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

## D

### Day Care Treatment

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

### Deductible

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

### Dentist

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

### Detoxification

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

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

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

### Directory

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

## Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

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

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

## E

### E-visit

An **E-visit** is an online internet consultation between a **physician** and an established patient about a non-emergency healthcare matter. This visit must be conducted through an **Aetna** authorized internet E-visit service vendor.

### Emergency Care

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

### Emergency Medical Condition

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

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

### Experimental or Investigational

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

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

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

## G

### Generic Prescription Drug

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

## 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**.

## Home Host Provider

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

## 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 the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

### Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception 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 give services or supplies to an **IOE** patient in connection with specific transplants, procedures at a **negotiated charge**. A facility is an **IOE** facility only for those types of transplants, procedures for which it has signed a contract.

# **J**

## **Jaw Joint Disorder**

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of 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 Booklet.

## **Lifetime Maximum**

This is the most the plan will pay for **covered expenses** incurred by any one covered person in their lifetime.

## **L.P.N.**

A licensed practical or vocational nurse.

# **M**

## **Mail Order Pharmacy**

An establishment where **prescription drugs** are legally given out by mail or other carrier.

## **Maintenance Care**

Care made up of services and supplies that:

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

## Maximum Out-of-Pocket Limit

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

## Medically Necessary or Medical Necessity

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

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

The provision of the service, supply or **prescription drug** must be:

- 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 mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

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

## Mental Disorder

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

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

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

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

## Morbid Obesity

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

## N

### Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is 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.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** 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 or **pharmacy** 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-Designated Network Specialists

These are **network providers** who have not been designated as **Aexcel Designated Network Specialists** by **Aetna**.

## 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-Preferred Drug (Non-Formulary)

A **prescription drug** that is not listed in the **preferred drug guide**. This includes **prescription drugs** on the **preferred drug guide exclusions list** that are approved by medical exception.

## 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 or **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies for this plan.

## P

### Partial Confinement Treatment

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

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

### Payment Percentage

**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.

### Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

## Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance 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.

## Preferred Drug Guide

A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at [www.Aetna.com/formulary](http://www.Aetna.com/formulary).

## Preferred Drug Guide Exclusions List

A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

## Preferred Network Pharmacy

A **network retail pharmacy** that has contracted with **Aetna**, an affiliate, or a third party vendor, to provide outpatient **prescription drugs** that we have identified as a **preferred network pharmacy**.

## Prescriber

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

## Prescription

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

## Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

## Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **primary care physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; 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 infirmity-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 amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all amounts above the **recognized charge**. The **recognized charge** may be less than the provider's full charge.

Your plan's **recognized charge** applies to all out-of-network **covered expenses** except out of network **emergency services**. It applies even to charges from an **out-of-network provider** in a **hospital** that is a **network provider**. It also applies when your **PCP** or other **network provider** refers you to an **out-of-network provider**. In all cases, the **recognized charge** is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the **recognized charge** for each service or supply is the lesser of what the **provider** bills and:

- For professional services and for other services or supplies not mentioned below:
  - The reasonable amount rate
- For **prescription drugs**:
  - 110% of the Average wholesale price (AWP)

The **recognized charge** is the **negotiated charge** for **providers** with whom we have a direct contract but are not **network providers** or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of **Aetna**.

If your ID card displays the National Advantage Program (NAP) logo, the **recognized charge** is the rate we have negotiated with your NAP provider. Your out-of-network cost sharing applies when you get care from NAP **providers**, except for **emergency services**.

A NAP **provider** is a **provider** with whom we have a contract through any third party that is not an affiliate of **Aetna** or through the Coventry National or First Health Networks. However, a NAP **provider** listed in the NAP directory is not a **network provider**.

We have the right to apply **Aetna** reimbursement policies. Those policies may further reduce the **recognized charge**. These policies take into account factors such as:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- 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 and
- The educational level, licensure or length of training of the **provider**

**Aetna** reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice and
- The views of **physicians** and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

#### Special terms used

Average wholesale price (AWP), Geographic area, and Reasonable amount rate are defined as follows:

#### Average wholesale price (AWP)

Is the current average wholesale price of a **prescription drug** listed in the Medi-span weekly price updates (or any other similar publication chosen by **Aetna**).

#### Geographic area

The Geographic area made up of the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider Geographic area such as an entire state.

#### Reasonable amount rate:

There is not a single “reasonable” amount. Your plan establishes the “reasonable” amounts as follows:

- For professional services:
  - The 90th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we reserve the right to substitute an alternative. If the alternative data source does not contain a value for a particular service or supply, we will base the **recognized charge** on the Medicare allowable rate.

#### **Additional information:**

Get the most value out of your benefits. Use the “Estimate the Cost of Care” tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. **Aetna’s** secure member website at [www.aetna.com](http://www.aetna.com) may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the “Estimate the Cost of Care” feature. Within this feature, view our “Cost of Care” and “Member Payment Estimator” tools.

## Rehabilitation Facility

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

## Rehabilitative Services

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

## Residential Treatment Facility (Mental Disorders)

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

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association’s Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient’s **illness** and risk;
- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;

- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A **behavioral health provider** must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a **psychiatrist** at least once per week; and
- The medical director must be a **psychiatrist**.

## Residential Treatment Facility (Substance Abuse)

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

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by **Aetna**;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's **illness** and risk;
- Provides access to psychiatric care by a **psychiatrist** as necessary for the provision of such care;
- Provides treatment services that are managed by a **behavioral health provider** who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility**, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a **behavioral health provider** or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a **physician** who is an addiction **specialist**.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An **R.N.** is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a **physician**.

## R.N.

A registered nurse.

## Room and Board

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

# S

## Self-injectable Drug(s)

**Prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

## 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**.

## Specialty Care Drugs

**Injectable**, infusion and oral **prescription drugs** that are prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis.

You can access the list of these **specialty care prescription drugs** by calling the toll-free number on your Member ID card or by logging on to your Aetna Navigator® secure member website at [www.aetna.com](http://www.aetna.com)

## Specialty Pharmacy Network

A network of pharmacies designated to fill **specialty care drugs**.

## Stay

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

## Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at [www.Aetna.com/formulary](http://www.Aetna.com/formulary).

## Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

## Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.

- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

## T

### Terminally Ill (Hospice Care)

**Terminally ill** means a medical prognosis of 12 months or less to live.

### Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

## U

### Urgent Admission

A **hospital** admission by a **physician** due to:

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

### Urgent Care Facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an **urgent condition**.

## Urgent Care Provider

This is:

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

It is not the emergency room or outpatient department of a **hospital**.

## Urgent Condition

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

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

## W

### Walk-in Clinic

**Walk-in Clinics** are free-standing health care facilities. They are an alternative to a **physician's** office visit for treatment of:

- Unscheduled, non-emergency **illnesses** and **injuries**;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a **physician**.

Neither:

- An emergency room; nor
- The outpatient department of a **hospital**;

shall be considered a **Walk-in Clinic**.

# IMPORTANT HEALTH CARE REFORM NOTICES

## CHOICE OF PROVIDER

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

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

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

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

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

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

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

## Notice Regarding Women's Health and Cancer Rights Act

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

- (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/home/regsguidance.asp>, and this U.S. Department of Labor website, [http://www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).