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State of Delaware
CDH Gold Plan Summary Plan Booklet
Open Choice - Aetna HRA Fund - Consumer Directed Health Plan

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Preface

Customer service professionals (CSPs) are trained to answer your questions and to assist you in using the Plan properly and efficiently. Call the Aetna Member Services toll-free number on your ID call (**877-54-AETNA** or 877-542-3862).

Employer:
State of Delaware

Contract Number:
863728

Effective Date:
July 1, 2013

Preface

The medical benefits plan described in this Booklet is a benefit plan of the State of Delaware's Group Health Insurance Program. These benefits are not insured with Aetna but will be paid from the Group Health Insurance Program funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Aetna agrees with the State of Delaware's Group Health Insurance Program to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this Booklet.

The State of Delaware CDH Gold Plan is an Aetna HRA Fund Open Choice® PPO Plan. This Booklet describes your rights and obligations, what the Aetna medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this Booklet. Your Booklet includes the Schedule of Benefits and any amendments.

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

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.

Schedule of Benefits

Aetna HRA Fund

Plan Features

Annual HRA Fund Amount

$1,250 Individual

$2,500 Family

Schedule of Benefits

The HRA Fund benefit will pay 100% of eligible HRA Fund expenses (network and out-of-network). Once your maximum HRA Fund benefit is paid, you will be responsible for covered expenses until the deductible is met. Once your deductible has been met, your health expense coverage will begin to pay for covered expenses.

PPO Medical Plan - CDH Gold Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Year Deductible*		
Individual	$1,500	$1,500
Family	$3,000	$3,000
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.		
Plan Payment Limit (excludes plan deductible, copayments and precertification penalties)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
*Unless otherwise indicated, any applicable deductible must be met before benefits are paid.		
Lifetime Maximum Benefit Per Person	Unlimited	Unlimited

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 Plan 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 and other health care, unless specifically stated otherwise.

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
WELLNESS BENEFITS	**Routine Physical Exams**		
	Adults only Includes coverage for immunizations.	100% per exam No deductible applies.	70% per exam after Plan Year deductible
	Maximum Exams per Plan Year		
	Adults, age 22 to 65	1 exam	1 exam
	Adults, age 65 and over	1 exam	1 exam
	Well Child Exams		
	Includes coverage for immunizations.	100% per exam No deductible applies.	70% per exam after Plan Year deductible
	Maximum Exams per Plan Year		
	Under age 3		
	first 12 months of life	7 exams	7 exams
	13th-24th months of life	3 exams	3 exams
	25th-36th months of life	3 exams	3 exams
	From age 3 to age 22	1 exam	1 exam

PPO Medical Plan - CDH Gold Plan

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
WELLNESS BENEFITS		
Screening & Counseling Services		
Obesity, Misuse of Alcohol and/or Drugs and Use of Tobacco Products	100% per visit No copay or deductible applies.	70% per visit after calendar year deductible
Obesity Maximum Visits per 12 months (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	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)*
Misuse of Alcohol and/or Drugs Maximum Visits per 12 months	5 visits*	5 visits*
Use of Tobacco Products Maximum Visits per 12 months	8 visits*	8 visits*
Routine Gynecological Exam	100% per exam No deductible applies.	70% per exam after Plan Year deductible
Maximum Exams per Plan Year	1 exam	1 exam
Hearing Exam	100% per exam No deductible applies.	70% per exam after Plan Year deductible
Maximum Exams per 12 consecutive month period	1 exam	1 exam
Hearing Supply Maximum: Unlimited*** Covers 1 hearing aid per ear every 3 years for child to age 24.	90% after deductible 1 hearing aid per ear every 3 years for child to age 24.	70% after deductible 1 hearing aid per ear every 3 years for child to age 24.

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

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
ROUTINE CANCER SCREENINGS	**Routine Mammography** For women age 40+	100% per test No deductible applies.	70% per test after Plan Year deductible
	Maximum tests per Plan Year	1 test	1 test
	Prostate Specific Antigen Test For covered males age 40 and over.	100% per visit No deductible applies.	70% per visit after Plan Year deductible
	Maximum tests per Plan Year	1 test	1 test
	Routine Digital Rectal Exam For covered males age 40 and over.	100% per visit No deductible applies.	70% per visit after Plan Year deductible
	Maximum tests per Plan Year	1 test	1 test
	Routine Pap Smears	100% per test No deductible applies.	70% per test after Plan Year deductible
	Maximum Tests per Plan Year	1 test	1 test
	Fecal Occult Blood Test	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.
	Maximum Tests per Plan Year	1 test	1 test
	Sigmoidoscopy Age 50 and over	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.
	Maximum Tests per 5 consecutive year period	1 test	1 test

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
ROUTINE CANCER SCREENINGS	**Double Contrast Barium Enema (DCBE)** Age 50 and over	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.
	Maximum Tests per 5 consecutive year period	1 test	1 test
	Colonoscopy age 50 and over	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.
	Maximum tests per 10 consecutive year period	1 test	1 test
FAMILY PLANNING SERVICES	**Voluntary Sterilization (women)**	100% No deductible applies.	Payable in accordance with the type of expense incurred and the place where service is provided.
	Voluntary Sterilization (men)	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.
	Contraceptive Devices and Injectibles (provided and billed by a physician – including insertion/administration)	100% No deductible applies.	100% No deductible applies.
	Contraceptive Counseling first 2 visits per plan year	100% No deductible applies.	70% per visit after Plan Year deductible
	subsequent visits	Payable in accordance with the type of expense incurred and the place where service is provided.	70% per visit after Plan Year deductible

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN SERVICES	**Lactation Support** visits 1-6 in a 12-month period	100% No deductible applies.	70% per visit after Plan Year deductible
	subsequent visits	Payable in accordance with the type of expense incurred and the place where service is provided.	70% per visit after Plan Year deductible
	Breast pumps and supplies 1 manual or electric breast pump per 36-month period (coverage to rent or purchase is at the discretion of Aetna)	100% No deductible applies.	70% per visit after Plan Year deductible
	Physician Office Visits (non-surgical)	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Specialist Office Visits	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Physician Office Visits-Surgery	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Walk-In Clinic Non-Emergency Visit	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Physician Services for Inpatient Facility and Hospital Visits	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Administration of Anesthesia	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible
	Allergy Testing and 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.

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
PHYSICIAN SERVICES	**Allergy Injections**	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.
	Immunizations (when not part of the physical exam)	100% per visit No deductible applies	70% per visit after Plan Year deductible
	Routine Prenatal Office Visits	100% per exam No deductible applies.	70% per visit after Plan Year deductible
	NOTE: The initial visit to confirm pregnancy, delivery and postnatal care, and additional services such a laboratory tests or care required due to complications of pregnancy are not considered routine maternity care. Such expenses are payable in accordance with the type of expense incurred.		
EMERGENCY MEDICAL SERVICES[1]	**Hospital Emergency Facility**	90% per visit after Plan Year deductible	90% per visit after Plan Year deductible
	IMPORTANT NOTE: Please note out of network providers do not have a contract with Aetna. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider 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.		
	Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered
URGENT CARE SERVICES	**Urgent Medical Care** (at a non-hospital free standing facility)	90% per visit after Plan Year deductible	70% deductible per visit after Plan Year deductible
	Urgent Medical Care (from other than a non-hospital free standing facility)	Refer to Emergency Medical Services and Physician Services above.	Refer to Emergency Medical Services and Physician Services above.

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT DIAGNOSTIC AND PREOPERATIVE TESTING	**Diagnostic and Preoperative Testing** (except complex imaging services)	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible
COMPLEX IMAGING SERVICES	**Complex Imaging** Services must be precertified except when rendered in the emergency room or if inpatient.	90% per test after Plan Year deductible	70% per test after Plan Year deductible
	Complex Imaging Services, including but not limited to: Magnetic Resonance Imaging (MRI); Computerized Axial Tomography (CAT); and Positron Emission Tomography (PET) ; and other outpatient diagnostic imaging service.		
DIAGNOSTIC LABORATORY TESTING	**Diagnostic Laboratory Testing**	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible
DIAGNOSTIC X-RAYS	**Diagnostic X-Rays**	90% per procedure after Plan Year deductible	70% per procedure after Plan Year deductible

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SURGERY	**Outpatient Surgery**	90% per visit/surgical procedure after Plan Year deductible	70% per visit/surgical procedure after Plan Year deductible
INPATIENT FACILITY EXPENSES	**Birthing Center**	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
	Hospital Facility Expenses Room and Board (including maternity)	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Skilled Nursing Inpatient Facility	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Maximum Days per Plan Year	120 days	120 days
SPECIALTY BENEFITS	**Home Health Care (Outpatient)**	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Maximum Visits per Plan Year combined with Private Duty Nursing	240 visits	240 visits
	Private Duty Nursing (Outpatient)	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Maximum Visit Limit per Plan Year. Combined with Home Health Care	Private Duty Nursing Shifts: Eight (8) hours equal one shift.	Private Duty Nursing Shifts: Eight (8) hours equal one shift.

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
HOSPICE BENEFITS	**Hospice Care** Facility Expenses (Room & Board)	90% per admission after the Plan Year deductible	70% per admission after the Plan Year deductible
	Hospice Care Other Expenses during a stay	90% per admission after the Plan Year deductible	70% per admission after the Plan Year deductible
INFERTILITY TREATMENT	**Basic Infertility Expenses** Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	75% per visit after Plan Year deductible	55% per visit after Plan Year deductible
	Comprehensive Infertility Expenses	75% per visit after Plan Year deductible	55% after Plan Year deductible
	Maximum per lifetime*	$10,000 *	$10,000*
	*Does not apply toward the plan payment limit Combined with Advanced Reproductive Technology (ART) Expenses		
	Advanced Reproductive Technology (ART) Expenses	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.
	Maximum per lifetime*	$10,000	$10,000
	*Does not apply toward the plan payment limit Combined with Artificial Insemination and Ovulation Induction		

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
INPATIENT TREATMENT OF MENTAL DISORDERS	**Hospital Facility Expenses**		
	Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Physician Services	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Inpatient Residential Treatment		
	Facility Expenses	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Physician Services	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
OUTPATIENT TREATMENT OF MENTAL DISORDERS	**Outpatient Services**	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
INPATIENT TREATMENT OF SUBSTANCE ABUSE	**Hospital Facility Expense**		
	Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Other than Room and Board	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Physician Services	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible
	Inpatient Residential Treatment		
	Facility Expenses	90% per admission after Plan Year deductible	70% after Plan Year deductible
	Physician Services	90% after Plan Year deductible	70% after Plan Year deductible
OUTPATIENT TREATMENT OF SUBSTANCE ABUSE	**Outpatient Treatment**	90% per visit after Plan Year deductible	70% per visit after Plan Year deductible

	PLAN FEATURES	NETWORK (IOQ FACILITY)	NETWORK (NON IOQ FACILITY)	OUT-OF-NETWORK
OBESITY TREATMENT NON SURGICAL	**Outpatient Obesity Treatment (non surgical)**	90% per visit after Plan Year deductible	75% per visit after Plan Year deductible	55% per visit after Plan Year deductible
OBESITY TREATMENT SURGICAL	**Inpatient Morbid Obesity Surgery** (Includes Surgical procedure and Acute Hospital Services). To receive the highest level of coverage services must be rendered at an approved Institutes of Quality® (IOQ) facility.	90% per admission after Plan Year deductible	75% per admission after Plan Year deductible	55% per admission after Plan Year deductible
	Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Unlimited	Not Covered

	PLAN FEATURES	NETWORK (IOE FACILITY)	NETWORK (NON OE FACILITY)	OUT-OF-NETWORK
TRANSPLANT SERVICES FACILITY AND NON-FACILITY EXPENSES	**Facility Expenses**	90% per admission after Plan Year deductible	70% per admission after Plan Year deductible	70% per admission after Plan Year deductible
	Physician Services (including office visits)	90% after Plan Year deductible	70% after Plan Year deductible	70% after Plan Year deductible

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
OTHER COVERED HEALTH EXPENSES	**Acupuncture in lieu of anesthesia**	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.
	Ground, Air or Water Ambulance	90% after Plan Year deductible	70% after Plan Year deductible
	Durable Medical and Surgical Equipment	90% per item after Plan Year deductible	70% per item after Plan Year deductible
	Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
	Prosthetic Devices	90% after Plan Year deductible	70% after Plan Year deductible.
OUTPATIENT THERAPIES	**Chemotherapy**	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
	Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
	Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PPO Medical Plan - CDH Gold Plan

	PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
SHORT TERM OUTPATIENT REHABILITATION THERAPIES	**Outpatient Physical, Occupational, and Speech Therapy**	90% per visit after Plan Year deductible Subject to medical necessity review at 25 visits	70% per visit after Plan Year deductible Subject to medical necessity review at 25 visits
AUTISM DISORDERS	**Autism Spectrum Disorder** Services are coveraged to age 21	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.
	Maximum Benefit per Plan year for Applied Behavioral Analysis	$36,000	$36,000
	IMPORTANT NOTICE: Coverage is not subject to any limits in the number of visits to an autism service provider for treatment of autism spectrum disorders.		
SPINAL MANIPULATION[5]	**Spinal Manipulation** (Chiropractic Care)	90% per visit after Plan Year deductible	75% per visit after Plan Year deductible
	Maximum visits per Plan Year	30 visits	30 visits

Expense Provisions

Deductible Provisions

Network Plan Year Deductible

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

Out-of-Network Plan Year Deductible

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

Covered expenses applied to the out-of-network deductible will be applied to satisfy the network deductible and covered expenses applied to the network deductible will be applied to satisfy the out-of-network deductible.

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.

Payment Limit

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

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

There is also a Family Payment Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Plan Year meets the Family Payment Limit amount in the Schedule of Benefits, the plan will pay 100% of covered expenses for the remainder of the Plan Year for all covered family members.

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

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

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

- Charges over the recognized charge;
- Non-covered expenses; and,
- Expenses for non-emergency use of the emergency room.

Maximum Benefit Provisions

Plan Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Plan Year is called the Plan Year maximum benefit.

The Plan Year maximum benefit applies to network care and out-of-network care expenses combined.

Eligibility

Eligibility

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

Who Can Be Covered

Your plan may cover:

- You;
- Your spouse by marriage or civil union;
- Your children.

NOTE: The State of Delaware requires proof of dependency.

You are eligible to be covered if:

- You are a regular officer or employee of the State;
- You are a regular officer or employee of a State agency or school district;
- You are a pensioner already receiving a State pension;
- You are a per diem and contractual employee of the Delaware General Assembly and have been continuously employed for 5 or more years;
- You are regularly scheduled full-time employee of any Delaware authority or commission participating in the State's Group health Insurance Program;
- You are a regularly scheduled full-time employee of the Delaware Stadium Corporation or the Delaware Riverfront Corporation;
- You are a paid employee of any volunteer fire or volunteer ambulance company participating in the State's Group Health Insurance Program;
- You are a regularly scheduled full-time employee of any county, soil and water conservation district or municipality participating in the Group Health Insurance Program;
- You are receiving or eligible to receive retirement benefits in accordance with the Delaware County and Municipal Police/ Firefighter Pension Plan with Chapter 88 of Title 11 of the Delaware Code or the county and municipal pension plan under Chapter 55A of Title 29 of the Delaware Code.
- You are a pensioner eligible to receive a State pension.

Coverage Administration for Spouses

Spouse

You may enroll your spouse. A spouse is one of two persons united in either:

- Marriage; or
- Civil union

...that is recognized by and valid under Delaware law.

Information on civil union or same-gender marriage, including Frequently Asked Questions (FAQ), tax dependent status, coverage codes, health plan rates and enrollment is available at www.ben.omb.delaware.gov/cusgm.

The benefits for spouses enrolled under this contracted health plan are as follows:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
  - is eligible for, and,
  - is enrolled in a health benefit plan sponsored by his/her employer or by an organization from which he or she is collecting a pension benefit.
- We pay 20% of allowable covered charges if your spouse's employer provides a benefit

plan, or an organization from which your spouse is collecting a pension provides a benefit plan, and your spouse:

- is eligible for, and,
- is not enrolled in that plan.

The combined payments can't be more than 100% of covered charges. Additional information can be found in the Coordination of Benefits section.

Children

To be covered, a child must be:

- under age 26; and
- either:
  - born to you or your spouse;
  - adopted by you or your spouse; or,
  - placed in your home for adoption; or,
- someone for whom health care coverage is your or your spouse's responsibility under the terms of a Qualified Medical Child Support Order. A copy of the order must be provided to your Human Resources/Benefits Office.

The State of Delaware requires proof of dependency when submitting application for coverage such as a birth certificate of adoption papers.

Disabled Children

Disabled children can be covered after age 26. They may be covered if:

- They were continuously covered as a dependent by a parent's health plan before reaching age 26;
- They are not married;
- They cannot support themselves because of a disability;
- Their disability happened before age 26;
- They depend on you for at least 50% of support;
- Disability is expected to last more than 12 months or result in death; and
- They are not eligible for coverage under Medicare, unless federal or state law requires otherwise.

Other rules may apply in the case of divorced parents.

You must file a Request for Continuation of Coverage for Handicapped Child form with Aetna. A Handicapped Child Attending Physician Statement is also required. Forms are available at www.ben.omb.delaware.gov/medical/aetna. Aetna can also provide you with the forms if you request them from Aetna Member Services.

You must print the form, complete it, obtain physician's information and signature, and mail the form to Aetna at the address provided on the form.

Coverage for Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- Unmarried; and
- Living with you in a regular parent-child relationship; and
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152; and
- Is under age 19; or
- Is a full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 20 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support for the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at www.ben.omb.delaware.gov/medical/aetna. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each

time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at www.ben.omb.delaware.gov/medical/aetna. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage

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

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

b. You or your eligible dependent previously declined coverage in writing under the Plan;

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

   i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted; or,

   ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated because you or your dependent lose eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes the following:

- a loss of coverage as a result of legal separation, divorce, or death;
- termination of employment;
- reduction in the number of hours of employment;
- any loss of eligibility after a period that is measured by reference to any of the foregoing;
- termination of Plan coverage due to you or your dependent moving outside of the Plan's service area; and also the termination of health coverage including Non-HMO, due to plan termination;
- plan ceases to offer coverage to a group of similarly situated individuals;
- cessation of a dependent's status as an eligible dependent;
- termination of benefit package;
- with respect to coverage under Medicaid or an S-Chip Plan (State Children's Health Insurance Program), you or your dependents no longer qualify for such coverage.

d. You or your dependents become eligible for premium assistance, with respect to coverage under the Plan, under Medicaid or an S-Chip Plan.

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

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

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

Medicare Eligibility and Enrollment

You, and your spouse, are eligible to enroll in Medicare Parts A and B based on age when you turn 65 or sooner based on being disabled. In accordance with 29 Delaware Code § 5203(b) and the State of Delaware's Group Health Insurance Program's Eligibility and Enrollment Rule 4.08 you and your spouse must enroll in Medicare upon

eligibility. Failure to enroll and maintain enrollment in Medicare Parts and B when eligible may result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. The following information is for you and your spouse.

Medicare Part A helps cover inpatient care in hospitals and is provided at no charge to you. Medicare Part B helps cover doctors' and other health care providers' services, outpatient care, durable medical equipment, and home health care and is provided to you at a monthly cost to you as determined by the Social Security Administration.

If you are a benefit eligible active employee, or the spouse of a benefit eligible active employee, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Part A;
- Advise your Human Resources/Benefits Office that you have applied;
- When you receive your Medicare Part A card, provide your Human Resources/ Benefits Office with a copy of your card.

Active employees and their spouses who are age 65 or older have a right to decide which medical plan will be their primary insurer: either the employer health plan or Medicare. If you or your spouse selects Medicare as primary, the State cannot offer or subsidize a health plan to supplement Medicare's benefits. If you choose, Aetna may remain your primary plan while you are an active employee.

- About three months before retirement, you must apply for Medicare Part B

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, about three months before turning 65:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your identification card. The Office of Pensions will enroll you in a Medicare Supplement, Special Medicfill, plan to cover costs not covered by Medicare Parts A and B.

If you are a State of Delaware pensioner, or the spouse of a State of Delaware pensioner, and are disabled or become disabled, regardless of age:

- Visit your local Social Security Administration Office and apply for Medicare Parts A and B;
- Advise the State's Office of Pensions that you have applied;
- When you receive your Medicare Parts A and B card, provide the State's Office of Pensions with a copy of your identification card. The Office of Pensions will enroll you in a Medicare Supplement, Special Medicfill, plan to cover costs not covered by Medicare Parts A and B.

If you are denied enrollment in Medicare Parts A and/or B, then you are required to appeal and provide a copy of the denial and your appeal to the State's Office of Pensions. Failure to enroll and maintain enrollment in Medicare Parts A and B when eligible will result in you, as the subscriber, being held financially responsible for the cost of the claims incurred, including prescription costs, for you and your spouse. Should Medicare deny your appeal and you provide a copy of the denial to the State's Office of Pensions, then you will continue to be covered under your Aetna plan with the State's Group Health Insurance Plan.

NOTE: The classification of being "disabled" by the State of Delaware as it relates to your ability to perform your job for the State of Delaware (or another employer for a spouse) may differ from the classification of being "disabled" by the Social Security Administration, it is always your responsibility to provide the State's Office of Pensions with your current classification by the Social Security Administration.

There are special Medicare requirements regarding some health conditions, such as End Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease). Generally, you may apply to have the standard 24-month Medicare eligibility waiting period waived if you have been diagnosed with either of these conditions. Upon receiving a diagnosis of either of these conditions, whether you are an active employee or pensioner or spouse, you should contact Aetna's Customer Services at 1-877-542-3862 and request information on the Medicare requirements.

Enrollment

Types of Enrollment

You may enroll in one of these coverage types:

- Employee for you only;
- Employee and Child (ren) for you and your family;
- Employee and Spouse for you and your spouse; or,
- Family for you, your spouse and your children.

Enrollment Date

Your enrollment date is the later of:

- Your date of hire for Timely Enrollees (if you're in an employee class eligible for health coverage);
- The date you move to an employee class that is eligible for health coverage (such as going from part-time to full-time employee); or,
- The date coverage begins if you're a Special Enrollee or a Late Enrollee.

How to Enroll

You may enroll yourself and your dependents when you are first eligible or at open enrollment by completing the enrollment process as designated by your Human Resources/Benefits Office. If you want to cover your spouse, you'll need to complete the Spousal Coordination of Benefits Form. See your Human Resources/Benefits Office to get the enrollment information. The Spousal Coordination of Benefits form is available at https://secomb.delaware.gov/cob.

How to Decline Coverage

You may decline coverage if you don't want to enroll when you are first eligible. You will need to complete the enrollment process indicating that you are waiving coverage as designated by your Human Resources/Benefits Office.

Pre-existing Conditions

A pre-existing condition is an injury or illness (excluding pregnancy) for which medical advice, diagnosis, care or treatment was received during the three months before enrollment in this Plan. This Plan does not include any exclusions or limitations for expenses related to any pre-existing condition.

When Coverage Begins

When your coverage begins is determined by:

- When you are eligible for coverage; and,
- When you enroll for coverage.

There are three categories of enrollees based on when you enroll for coverage. You can be a:

- Timely Enrollee;
- Special Enrollee; or,
- Late Enrollee.

Timely Enrollees

You are a Timely Enrollee if you enroll within 30 days (31 days for newborns) of when you are first eligible to be covered.

Coverage for new employees (and their dependents) begins on:

- The first of the month following the employee's hire date (the employee pays the entire month's premium); or,
- The first of the month following three full months of employment (State Share becomes effective and employee pays Employee Share of premium).

Special Enrollees

You are a Special Enrollee if you request enrollment within the 30-day enrollment period. The enrollment period is within 30 days of:

- Losing other health coverage under certain conditions;
- Obtaining a new dependent because of marriage, civil union, birth (enrollment period is 31 days, see Changes in Enrollment / Newborns section), adoption, or placement in the home for adoption, or court ordered support.

Employees or dependents may qualify as Special Enrollees if the following requirements are met:

- Employees: if you're not already enrolled in this plan, you must:
  - be eligible to enroll in this plan; and,
  - enroll at the same time you enroll a dependent.
- Spouses and Children: you're a dependent of an employee:
  - who is already enrolled or is eligible to enroll in this plan; and,
  - who enrolls at the same time you enroll.

If you don't request enrollment within the 30-day enrollment period, you are a Late Enrollee.

Loss of Other Coverage

To qualify as a Special Enrollee because of loss of coverage, you (the employee or dependent) must meet all these conditions:

- You were covered under another group or individual health plan when coverage was previously offered under this plan (when first eligible or during open enrollment);
- When this plan was previously offered, you declined coverage under this plan because you had other coverage; and,
- The other coverage was either:
  - COBRA continuation coverage that is exhausted; or,
  - other (non-COBRA) coverage that was lost because:
  - you are no longer eligible;
  - the lifetime limits under the other coverage were reached;
  - the employer stopped contributing; and,
  - you enrolled within 30 days of the date other coverage was lost; and
- You can prove the loss of the other coverage by providing proof of coverage, such as a Certificate of Coverage.

New Dependents

You (employee or dependent) are a Special Enrollee if the employee gets a new dependent because of:

- A marriage or civil union;
- Birth;
- Adoption;
- Placement of a child in the home for adoption; or,
- Court ordered support.

Coverage for Special Enrollees begins as follows if the Human Resources/Benefits Office was notified of a loss of coverage or new dependent within 30 days and your application and premium is subsequently submitted:

- Employees: the first day of the month after the loss of coverage.
- Spouses: either the date of the marriage or civil union or the first day of the month after the marriage or civil union.
- Children: either:
  - the date of birth, adoption or placement in the home for adoption;
  - the first day of the month after you request enrollment if:
  - you lost coverage under a prior plan; or,
  - your parents got married or entered into a civil union.

Remember, if you enroll after the 30-day enrollment period, you (and your dependents) will be Late Enrollees.

Don't forget, when you get married or enter into a civil union and add your spouse, you'll also need to complete the Spousal Coordination of Benefits Form, available at https://secomb.delaware.gov/cob/ and provide copy of your Marriage/Civil Union Certificate to your Human Resources/Benefits Office. The Spousal Coordination of Benefits Form must be completed and submitted online annually or when your spouse has a change of job status or health insurance status.

Late Enrollees

If you did not enroll as a Timely or Special Enrollee, you are a Late Enrollee. Late Enrollees can enroll at an open enrollment period.

Children are Late Enrollees if enrollment was not requested within 30 days of:

- Birth (31 days);
- Adoption;
- Placement in the home for adoption; or
- Parents married or entered into a civil union.

Coverage for Late Enrollees begins the first day of the new plan year.

Changes in Enrollment

You can change your enrollment because of one of the reasons described below. You must enroll yourself (and any dependents) within 30 days of the date of the event. You and your dependents will be late enrollees if you are not enrolled in the 30-day waiting period. Newborns must be enrolled within a 31-day period. See your Human Resources/Benefits Office. If added premium is due, you must pay when you enroll.

Marriage or Civil Union

You may add your spouse when you get married or enter into a civil union. You must request enrollment within 30 days after the marriage or civil union. If added premium is due, you must pay when you request enrollment. If you request enrollment within the 30-day period, your spouse will be a Special Enrollee. If you don't request enrollment within the 30-day period, your spouse will be a Late Enrollee.

Don't forget, when you get married or enter into a civil union you'll also need to complete the Spousal Coordination of Benefits Form and provide a copy of your marriage or civil union certificate to your Human Resources/Benefits Office. You may also add stepchildren you acquire when you marry or enter into a civil union. See section below describing coverage for other children.

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office will result in you being held financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

Newborns

You may add your newborn child. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. Hospital nursery care is covered for infants when the mother is having hospital obstetrical care. If a sick infant must stay in the hospital, the baby remains covered for the first 31 days after the infant's birth. There is no coverage after those 31 days unless:

- You have coverage that already covers dependent children. However, you must request enrollment for the child within 31 days of the child's birth in order for claims to process.

- You have coverage that doesn't cover dependent children and you request enrollment for coverage that includes children. You must request enrollment for the child within 31 days of the child's birth. If added premium is due, you must pay it when you enroll.

Upon enrollment, you must provide a valid copy of the child's birth certificate.

If you request enrollment within the 31-day period, the newborn will be a Special Enrollee. If you don't request enrollment within the 31-day period, the child will be a Late Enrollee.

Adopted Children

You may add a child because of adoption or placement in your home for adoption. A birth certificate or legal documentation needs to be supplied to your Human Resources/Benefits Office. You must request enrollment within 30 days of the date of adoption or placement in the home in order for the child to be a Special Enrollee. If you don't request enrollment within the 30-day period, the child will be a Late Enrollee.

Other Children

You may also cover a child who is not your or your spouse's natural or adoptive child if the child is:

- Unmarried; and
- Living with you in a regular parent-child relationship; and
- Dependent on you for support and qualifies as your dependent under Internal Revenue Code Sections 105 and 152; and
- Is under age 19; or
- A full-time student and under age 24.

For each child, you are required to show proof of dependency, such as a birth certificate, court order or federal tax return. The applicable documents must be provided to your Human Resources/Benefits Office upon enrollment. You must request enrollment within 30 days of the date the child became eligible.

You must also submit a Statement of Support form to verify you provide at least 50 percent support fo the child upon enrollment and any time there are changes to the support you provide. The Statement of Support form is available at www.ben.omb.delaware.gov/medical/aetna. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

You must also submit a Full-Time Student Certification form for each child between the ages of 19 and under age 24, when the child is initially eligible as a full-time student, each time the child's student status changes, and for each school semester. The Full-Time Student Certification form is available at www.ben.omb.delaware.gov/medical/aetna. Please print the form, complete it, and provide to your Human Resources/Benefits Office.

When Continuation of Coverage Under COBRA Ends

You may have declined coverage under this plan when you were first eligible because you chose to keep COBRA coverage with another plan. If you enroll in this plan before your COBRA continuation coverage is exhausted, you will be a Late Enrollee.

When your COBRA continuation coverage is exhausted, you may request enrollment in this plan within 30 days. If you request enrollment within the 30-day period, you will be a Special Enrollee. If you don't request enrollment within the 30-day period, you will be a Late Enrollee.

How Your CDH Gold PPO Medical Plan Works

How Your CDH Gold PPO 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 CDH Gold PPO Medical Plan

This CDH Gold Preferred Provider Organization (PPO) 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 CDH Gold PPO plan, you can directly access any physician, hospital or other health care provider (network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently when services and supplies are obtained through network providers or out-of-network providers.

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

On pages 115-119 are examples of how the Aetna CDH Gold plan works over a two-year period for both an individual and a family.

This CDH Gold PPO plan provides access to covered benefits through a network of health care providers and facilities. These network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members at a reduced fee called the negotiated charge. This CDH Gold PPO plan is designed to lower your out-of-pocket costs when you use network providers for covered expenses. Your deductibles and payment percentage will generally be lower when you use participating network providers and facilities.

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

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

Availability of Providers

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

Ongoing Reviews

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

To better understand the choices that you have with your CDH Gold PPO plan, please carefully review the following information.

How Your CDH Gold PPO Plan Works

Accessing Network Providers and Benefits

- You may select any network provider from the Aetna network provider directory or by logging on to Aetna's website at www.aetna.com/statede. From there, you can search Aetna's online directory, DocFind®, for names and locations of physicians and other health care providers and facilities. You can change your health care provider at any time.
  - If a service you need is covered under the plan but not available from a network provider, please contact Member Services 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 is no additional out-of-pocket cost to you as a result of a network provider's failure to

precertify services. Refer to the Understanding Precertification section for more information.

- You will not have to submit medical claims for treatment received from network providers. Your network provider will take care of claim submission. Aetna will directly pay the network provider less any cost sharing required by you. You will be responsible for deductibles and payment percentage, if any.
- You will receive notification of what the plan has paid toward your covered expenses. It will indicate any amounts you owe toward your deductible 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

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

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

Accessing Out-of-Network Providers and Benefits

- You have the choice to directly access physicians, hospitals or other health care providers that do not participate with the Aetna provider network. You will still be covered when you access out-of-network providers for covered benefits. Your out-of-pocket costs will generally be higher.
- 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. Deductibles and payment percentage are usually higher when you utilize out-of-network providers. Except for emergency services, Aetna will only pay up to the recognized charge.
- Precertification is necessary for certain 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 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, 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 physicians and hospitals that are not in the network you may have to pay for services at the time they are rendered. You may be required to pay the charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to an out-of-network provider. Aetna will reimburse you for a covered expense up to the recognized charge, less any cost sharing required by you.
- If your out-of-network provider charges more than the recognized charge, you will be responsible for any expenses incurred above the recognized charge. The recognized charge is the maximum amount Aetna will pay for a covered expense from an out-of-network provider.
- You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your deductible, payment percentage, or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

IMPORTANT NOTE: Failure to precertify will result in a reduction of benefits under this Booklet. Please refer to the Understanding Precertification section for information on how to precertify and the precertification benefit reduction.

Cost Sharing for Out-of-Network Benefits

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

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

Understanding Precertification

Precertification

Inpatient stays 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.

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

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 is not a covered expense, 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 of this Booklet.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

Inpatient and Outpatient Care

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment
- Home health care
- Private duty nursing care

Emergency and Urgent Care

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

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

In Case of a Medical Emergency

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

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

Coverage for Emergency Medical Conditions

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

IMPORTANT REMINDER: With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room.

In Case of an Urgent Condition

Call your physician 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 network provider, please do so as soon as possible after urgent care is provided. If you need help finding a network 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/docfind/custom/statede.

Coverage for an Urgent Condition

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

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

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

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

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

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

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

Requirements For Coverage

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

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

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

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

Aetna HRA Fund Plan®

Aetna HRA Fund is the name for the benefits in this section. Benefits under the "Health Fund" will be paid pursuant to HRA Fund plan provisions described herein. The Aetna HRA Fund provides a benefit to offset certain covered expenses received for health care services and supplies covered under this Booklet. The plan blends traditional health coverage with a fund benefit to help you pay for covered expenses. It does not provide benefits covering expenses incurred for all medical dental care.

NOTICE: The Aetna HRA Fund benefit is provided in addition the medical plan benefits described in this Booklet.

The Aetna HRA Fund is not a cash account and has no cash value. Aetna HRA Fund does not duplicate other coverage provided by this Booklet. It will be terminated under the When Coverage Ends section of your Booklet.

For additional information and examples of how the HRA Fund operates in conjunction with medical benefits, select the link to Aetna's Open Enrollment Booklet – All Plans at www.ben.omb.delaware.gov/medical/aetna.

HRA Fund Benefit Description

You and your covered dependents will be eligible under the Aetna HRA Fund benefit for payment of Eligible HRA Fund Expenses up to the Annual HRA Fund Amount.

The Annual HRA Fund Amount is the amount of coverage credited each Plan Year that is eligible for payment. The Annual HRA Fund amount can be found in the Schedule of Benefits. If you have not been enrolled in the plan for the full Plan Year, your HRA Fund Amount will be pro-rated.

The Annual HRA Fund amount may be adjusted by Aetna. The adjustment is equal to the amount of unused benefits provided under a similar program your employer sponsored prior to the effective date of coverage under this contract.

When Your HRA Fund Has a Year-end Balance

The balance of any Aetna HRA Fund amount remaining at the end of a Plan Year will be designated as the Unused HRA Fund Amount. This balance can be rolled over to the next Plan Year.

The Annual HRA Fund Amount for the first year is the Annual HRA Fund amount credited in the first Plan Year. The Annual HRA Fund amount in subsequent years is the sum of the Unused HRA Fund amount and the Annual HRA Fund benefit credited each Plan Year.

Aetna HRA Fund Pays First

The HRA Fund benefit will pay eligible HRA Fund network and out-of-network expenses. Once your maximum HRA Fund benefit is paid, you will be responsible for covered expenses until any deductible is satisfied. Once your deductible has been satisfied, your Health Expense Coverage will begin to pay for covered expenses.

Eligible Expenses

Eligible HRA Fund expenses that can be paid through the Aetna HRA Fund are the same as the services and supplies which constitute the covered expenses under this Booklet for health expenses. If the HRA Fund is depleted, you must satisfy the remaining applicable deductible amount under this Booklet.

Expenses that do not apply to the Aetna HRA Fund Benefit include:

- covered benefits paid at 100%;
- Services not covered by this Booklet.
- Health expenses included under covered benefits that are applicable to the deductible amount under this Booklet.

Payment of Aetna HRA Fund Benefits

Aetna will pay 100% of Aetna HRA Fund eligible expenses up to the HRA Fund amount for the Plan Year, or up to the prorated amount if you have not been enrolled in the plan for the full Plan Year.

Individual and Family Coverage

For the purposes of this plan, an individual means a single covered person enrolled for self only coverage with no dependent coverage. A family means a covered person enrolled with one or more dependents.

What the Plan Covers

What the Plan Covers

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

CDH Gold PPO 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.

Wellness

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

Routine Physical Exams

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

- Radiological services, X-rays, lab and other tests given in connection with the exam; and
- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Testing for Tuberculosis.

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

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

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

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

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

Screening and Counseling Services

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

Obesity

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

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

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

Misuse of Alcohol and/or Drugs

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

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

Use of Tobacco Products

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

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

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

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

Limitations:

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

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

For Covered Females

Screening and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

- Screening and counseling services for:
  - Interpersonal and domestic violence;
  - Sexually transmitted diseases; and
  - Human Immune Deficiency Virus (HIV) infections.
- Screening for gestational diabetes.
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older, limited to once every three years.

Routine Cancer Screenings

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

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

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

- 1 Sigmoidoscopy every 5 years for persons at average risk; or
- 1 Double contrast barium enema (DCBE) every 5 years for persons at average risk; or
- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer.

Family Planning Services

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

Contraception Services

Covered expenses include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.
- Office visit for the injection of injectable contraceptives;

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Other Family Planning

Covered expenses include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

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

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

Hearing Exam

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

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

The plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

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

Physician Services

Physician Visits

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

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

Surgery

Covered expenses include charges made by a physician for:

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

Anesthetics

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

IMPORTANT REMINDER: Certain procedures need to be precertified by Aetna. Refer to How the Plan Works for more information about precertification.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

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

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

Hospital Expenses

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

Room and Board

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

Room and board charges also include:

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

Other Hospital Services and Supplies

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

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

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

Outpatient Hospital Expenses

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

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

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

Hospital admissions need to be 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 a network provider after receiving treatment for an emergency medical condition.

IMPORTANT REMINDER: With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits. No other plan benefits will pay for non-emergency care in the emergency room.

Coverage for Urgent Conditions

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

Your coverage includes:

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

Please contact a network provider 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 continued your hospital stay.

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

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

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

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

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

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

Limitations

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

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

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

Home health care needs to be precertified by Aetna. Refer to How the Plan Works for details about precertification.

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

Skilled Nursing Facility

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

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

IMPORTANT REMINDER: Refer to the Schedule of Benefits for details about any applicable skilled nursing facility maximums.

Admissions to a skilled nursing facility must be 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 hospe 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.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

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

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

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

Limitations

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

Outpatient Diagnostic Lab Work and Radiological Services

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

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

Outpatient Preoperative Testing

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

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

Limitations

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

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

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

Durable Medical and Surgical Equipment (DME)

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

The initial purchase of DME if:

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

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

Replacement of purchased equipment if:

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

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

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

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

Experimental or Investigational Treatment

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

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

Pregnancy Related Expenses

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

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

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

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

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

Lactation Support, Counseling and Supplies

Covered expenses include charges made for comprehensive lactation support (assistance and training in breast feeding) and counseling services to females during pregnancy and in the post-partum period. Services must be provided by a certified lactation support provider in a group or individual setting.

Covered expenses also include the rental or purchase of breast feeding durable medical equipment for pumping and storage of breast milk and the purchase of the accessories and supplies needed to operate the equipment. Aetna reserves the right to limit the payment of charges 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 any deductible, payment percentage and limit that may apply to covered services.

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; and
- A durable brace that is custom made for and fitted for you.

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

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

Hearing Aids

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a prescription written during a covered hearing exam.

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

All covered expenses are subject to the hearing expense exclusions in this Booklet- and are subject to deductible(s), or coinsurance listed in the Schedule of Benefits, if any.

Benefits After Termination of Coverage

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

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

Short-Term Rehabilitation Therapy Services

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

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

Charges for the following short term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

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

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

Coverage is subject to the limits, if any, shown on the Schedule of Benefits. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this 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. Subject to medical necessity review at 25 visits.
- 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. Subject to medical necessity review at 25 visits.

- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from illness or injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Subject to medical necessity review at 25 visits.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

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

The therapy should follow a specific treatment plan that:

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

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

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

- Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders. Physical therapy, occupational therapy and speech therapy services for the treatment of Autism Spectrum Disorder are subject to the short-term rehabilitation maximum shown in in the Schedule of Benefits;
- Any services which are covered expenses in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a stay in a hospital, skilled nursing facility, or hospice facility except as stated above;
- Services not performed by a physician or under the direct supervision of a physician;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Autism Spectrum Disorders

Covered expenses include charges made by a physician or behavioral health provider for services and supplies for diagnosis and treatment of Autism Spectrum Disorder, including behavioral therapy and Applied Behavioral Analysis. Services and supplies must be ordered by a physician as part of a treatment plan, and incurred prior to attainment of age twenty-one.

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

- Systematically change behavior; and
- Are responsible for the observable improvement in behavior.

Autism Spectrum Disorder means one of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic Disorder;
- Rett's Disorder;
- Childhood Disintegrative Disorder;
- Asperger's Syndrome; and
- Pervasive Developmental Disorder – Not Otherwise Specified

Coverage for Applied Behavioral Analysis for Autism Spectrum Disorders is subject to the maximum shown in the Schedule of Benefits.

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 charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a hospital; or

- A physician in his/her office or in your home.

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

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

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

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

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

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

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

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

Treatment of Infertility

Basic Infertility Expenses

Covered expenses include charges made by a 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, subject to all the exclusions and limitations of this Booklet:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the Schedule of Benefits section of this Booklet and has a maximum of 6 cycles

per lifetime; (where lifetime is defined to include services received, provided or administered by Aetna or any affiliated company of Aetna); and

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

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

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

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

Eligibility for ART Benefits

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

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

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;
- Infertility Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not infertile.

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

Spinal Manipulation Treatment

Also known as Chiropractic Care. 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.

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; and
- Diagnostic tests given or ordered during the first exam.

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.

The highest network level of benefits is paid only for a treatment at a facility designated by the plan as a Bariatric Institutes of Quality® (IOQ) facility.

Services obtained from a facility that is a network facility but not designated as a Bariatric IOQ facility will be covered at a lower network level of benefits. Services obtained from an out-of-network facility will be covered at a lower out-of-network level of benefits.

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 this Booklet.

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 Health Plan Exclusions and Limits for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

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

Inpatient Treatment

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

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.

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 deductibles, maximums and Payment Limit 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 Health Plan Exclusions and Limits for more information.

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider.
- The program of therapy includes either:
  - A follow up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or substance abuse.

Please refer to the Schedule of Benefits for any substance abuse deductibles, maximums and Payment Limit 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 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 deductibles, maximums and Payment Limit 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 teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

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

a. Natural teeth damaged, lost, or removed; or

b. Other body tissues of the mouth fractured or cut due to injury.

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

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

Exclusions and Limitations

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.

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 (Rinkle 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 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

APPLIED BEHAVIORAL ANALYSIS, THE LEAP, TEACCH, DENVER AND RUTGERS PROGRAMS.

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, or an out-of-network provider in excess of the recognized charge.

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

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

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

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

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.

COURT ORDERED SERVICES, including those required as a condition of parole or release.

CUSTODIAL SERVICES.

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

- services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

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

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

DRUGS, MEDICATIONS AND SUPPLIES:

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

EDUCATIONAL SERVICES:

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

EXAMINATIONS:

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

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the What the Plan Covers section.

EXPERIMENTAL OR INVESTIGATIONAL DRUGS, DEVICES, TREATMENTS OR PROCEDURES, except as described in the What the Plan Covers section.

FACILITY CHARGES for care services or supplies provided in:

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

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

FOOT CARE: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

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

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

HEARING:

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

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

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

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

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

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

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- 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, outpatient private duty nursing services, and private duty nursing services provided outside of the home (e.g., while attending daycare, preschool or school) or while traveling, except as specifically described in the Private Duty Nursing provision in the What the Plan Covers Section.

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

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

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

SEXUAL DYSFUNCTION/ENHANCEMENT: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and

- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

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

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the 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;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

TRANSPLANT: The transplant coverage does not include charges for:

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

TRANSSEXUAL SURGERY, SEX CHANGE OR TRANSFORMATION. The Plan does not cover any procedure, treatment or related service designed to alter a Plan participant's physical characteristics from their biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

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 provided by this Booklet, including but not limited to:

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

WORK RELATED: Any illness or injury related to employment or self-employment including any 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.

Special Programs

Discount Arrangements

Aetna offers discount arrangements or special rates from certain service providers such as, optometrists, dentists, alternative medicine, wellness and healthy living providers to persons covered under the 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 covered persons for the provision of any such goods and/or services. Aetna reserves the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to covered persons nor does Aetna compensate providers for services they may render.

Aetna Natural Products and Services℠ Discount Programs

You and your family can save on complementary health care products and professional services, not traditionally covered by your health benefit plan, through the Aetna Natural Products and Services discount program. All products and services are delivered through American Specialty Health Incorporated (ASH) and its subsidiaries, American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc. ASH is a recognized leader in the complementary health care market.

You can access the following services from participating natural therapy professionals at reduced rates: acupuncture, chiropractic care, massage therapy and dietetic counseling. You can also purchase the following health-related products at a discount: over-the-counter vitamins, herbal and nutritional supplements, and natural products.

For more information or to locate participating natural therapy professionals, call the Member Services number on your ID card or visit the Aetna Natural Products and Services discount program page in Aetna Navigator® by logging onto our website at www.aetna.com.

Aetna Fitness℠ Discount Program

You and your family members can save on gym memberships, programs and other products and services that support your healthy lifestyle with the Aetna Fitness discount program, offered with services provided by GlobalFit™.

With the Aetna Fitness discount program, you have access to:

- Thousands of gyms nationwide and in Canada, including well-known national chains and independent local facilities
- Preferred rates*
- Flexible membership options, guest privileges** at participating network gyms when traveling and free guest passes** to try participating gyms before joining
- Convenient billing options

Plus more support for your healthy lifestyles with access to:

- At-home weight loss programs
- Home exercise products and equipment
- One-on-one health coaching services***

For more information, call the Member Services number on your ID card or visit the Aetna Fitness discount program page in Aetna Navigator® by logging onto our website at www.aetna.com. You can also contact GlobalFit directly at 1-800-298-7800.

*Participation in GlobalFit is for new gym members only. Membership to a gym of which you are now, or were recently, a member may not be available.
**Not available at all gyms.
***Provided by WellCall, Inc. through GlobalFit.

Aetna Hearing℠ Discount Program

Plan participants are eligible to receive discounts on hearing aids. The discount program includes savings on many styles, from complete canal to behind-the-ear hearing aids from leading manufacturers. Available devices include the newest technologies, such as programmable and digital instruments. Plan participants have a choice of over 1,800 participating locations across the country.

To access the discount program, members must call HearPO® customer service (weekdays, 9 a.m.-6 p.m., EST) at

1-888-HEARING (1-888-432-7464). Identify yourself as an Aetna member, and you will be sent a referral packet to a conveniently located provider. Make an appointment with your selected provider after you receive the packet, and you will receive the discounts at the point of sale.

Aetna Weight Management℠ Discount Program

Aetna's Weight Management discount program can help you achieve your weight loss goals and develop a balanced approach to your active lifestyle. This program provides Aetna members and their eligible family members access to discounts on eDiets® diet plans and products, Jenny Craig® weight loss programs and products and Nutrisystem® weight loss meal plans.

eDiets

You can save 30 percent on the online monthly plan membership dues. Once you enroll, you can upgrade to an online annual plan and save 20 percent on the already discounted annual plan price. When you enroll in an online plan, you can choose from over 20 online diet plans. Or, you can enroll in the Meal Delivery Plan (5-day or 7-day) and save 15 percent on the cost of food, delivered right to your door. Once you enroll in a plan, you'll receive one-on-one professional support, customized menus, unlimited access to the eDiets interactive community, a personalized fitness plan, live phone, chat and email support from certified and registered dieticians, 24/7 online member support and more.

You can also save 15 percent on all purchases from the eDiets Online Store and choose from DVDs, CDs, fitness and exercise equipment and more.

Jenny Craig

Start with a FREE 30-day program*, then receive 25 percent off a Jenny Craig Premium Program* available at participating Jenny Craig centres and through Jenny Craig At Home. You also receive individual weekly schedule weight loss consultations, personalized menu planning, tailored activity planning, motivational materials, 24/7 customer care support, online support and free Jenny e-tools, message boards, live chat and much more.

Nutrisystem

You can save 12 percent on any 28-day Nutrisystem® weight loss meal plan** plus any other discount offers available from Nutrisystem at the time you enroll. Choose from Basic, Silver, Diabetic, Vegetarian and the Nutrisystem®Select™ programs and take advantage of meal plans for men and women. Create your own 28-day menu (choose a breakfast, lunch, dinner and dessert for each day) or start with a pre-selected Favorite Foods Package, delivered right to your door. You'll also receive any easy-to-follow meal plan, free online membership with access to an extensive array of online tools, tracker, newsletter content and more, unlimited telephone and online counseling by trained weight loss counselors and dieticians, Online Mindset Makeover™ behavioral guide and much more.

*Food and, if applicable, shipping not included. Offer applies to initial membership fee only and is valid at participating centres in the U.S., Canada and Puerto Rico and through Jenny Craig At Home. Each offer is a separate offer and can be used only once per person. Restrictions apply.

**Aetna discount offers do not apply to any program in which you are already enrolled. To receive the discounted rate, you must wait until your current program ends. Discounts do not apply to Nu-Kitchen Fresh for Nutrisystem and Nutrisystem Flex.

Aetna Book℠ Discount Program

The Aetna Book℠ discount program provides you with access to discounts on books and other items purchased from the American Cancer Society Bookstore, the MayoClinic.com Bookstore and Pranamaya.

Through the American Cancer Society Bookstore and the MayoClinic.com Bookstore, you can choose from a variety of different books and other items like DVDs and greeting cards covering topics such as healthy living, staying in shape, living with certain health conditions and specific topics related to cancer. Through Pranamaya, choose from a variety of yoga DVDs, CDs, books and online videos featuring different yoga instructors and styles.

Through the American Cancer Society Bookstore, you will receive a 30% discount on your purchase of books, greeting cards and kits* plus free standard shipping to U.S. addresses. You can choose from two main categories, offering a selection of over 50 different books for adults and children:

- Stay Well - healthy living, disease prevention, smoking cessation, etc.
- Get Well - cancer treatments, side effects, caregiving, etc.

You will receive a 10% discount when you order online at the MayoClinic.com Bookstore, plus receive free standard shipping. (Mayo Clinic newsletters are regular price. No discounts apply.)

You can choose from 25 different categories. There are over 30 different books and DVDs containing recipes for healthy living, advice on staying in shape, guidance for living with certain health conditions, and more. Many publications are also available in Spanish**!

Through Pranamaya, you can save 25% on yoga DVDs, CDs, books and online videos.

Choose from a variety of products from well-renowned yoga instructors, including DVDs from Paul Grilley and Sarah Powers and Gary Kraftsow's acclaimed Viniyoga Therapy for Back Care series. You can also find products featuring different yoga styles, such as Vinyasa, Yin Yoga and more.

For more information, call the Member Services number on your ID card or visit the Aetna Book discount program page in Aetna Navigator® by logging onto www.aetna.com.

Salud is a third party Web site, which is not part of the MayoClinic.com Bookstore.

*Includes two or more books combined as a special discount package.

**Spanish publications are offered through Libros de Salud. No discounts apply. Libros de

When Coverage Ends

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

When Coverage Ends for Employees

Your Aetna health benefits coverage will end if:

- The Aetna health benefits plan is discontinued;
- You voluntarily stop your coverage;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer; or
- Your employer notifies Aetna that your employment is ended.
- The date of your death.

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

Coverage terminates at the end of the month in which you leave your job.

Your Proof of Prior Medical Coverage

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

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make the required contribution toward the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees;
- Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent; or
- Your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- Unless covered as a disabled child, your child's coverage ends at the end of the month in which he or she reaches:
  - age 26 if your natural or adopted child;
  - age 19 if eligible under the terms described in coverage for other children;
  - age 24 if similarly eligible and a full-time student.
  - The plan is canceled. (Coverage ends the day the State of Delaware's contract ends with Aetna.)

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

Divorce

Former spouses are not eligible for coverage under this program. You must notify your Human Resources/Benefits Office of the divorce and provide them with a copy of your divorce decree. An enrollment form/application must be completed within 30 days of the divorce. You should state "divorce" as the reason for the change.

Coverage ends on the day after the date the divorce is granted. Failure to provide notice of your divorce to your Human Resources/Benefits Office will result in you being held financially responsible for the cost of the premium as well as health care and prescription services provided to your former spouse and his or her children.

Continuation of Coverage

Continuing Health Care Benefits

Continuing Coverage for Dependent Students on Medical Leave of Absence

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

- a medically necessary leave of absence from school; or
- a change in his or her status as a full-time student,

resulting from a serious illness or injury, such child's coverage under this plan may continue.

Coverage under this continuation provision will end when the first of the following occurs:

- The end of the 12 month period following the first day of your dependent child's leave of absence from school, or a change in his or her status as a full-time student;
- Your dependent child's coverage would otherwise end under the terms of this plan;
- Dependent coverage is discontinued under this plan; or
- You fail to make any required contribution toward the cost of this coverage.

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

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

IMPORTANT NOTE: If at the end of this 12 month continuation period, your dependent child's leave of absence from school (or change in full-time student status) continues, such child may qualify for a further continuation of coverage under the Handicapped Dependent Children provision of this plan. Please see the section, Handicapped Dependent Children, for more information.

Handicapped Dependent Children

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

Your child is fully handicapped if:

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

Proof that your child is fully handicapped must be submitted to Aetna no later than 30 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

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

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

Continuation Your Coverage Under COBRA

You may continue your coverage after you lose coverage under this plan. This right is provided under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you decide to continue your coverage, you will have to pay up to 102% of the cost of coverage.

The following is a brief explanation of the law:

Employee

You (and your dependents) can continue coverage for up to 18 months if you lose group coverage because:

- your hours at work are reduced; or,
- your job ends (for reasons other than gross misconduct).

You, the employee, can continue coverage beyond 18 months if you:

- are disabled when you become eligible for COBRA coverage; and,
- are considered disabled under Social Security.

You are then entitled to an additional 11 months (totaling 29 months). Your cost would be 150% of the plan cost for months 19 through 29.

Spouse of Employee

Your spouse can continue coverage for up to 36 months if coverage ends because:

- you die;
- you divorce from your spouse; or,
- you become eligible for Medicare.

Dependent Child of Employee

A child can continue coverage for up to 36 months if coverage ends because:

- you die;
- you and your spouse are divorced or legally separated;
- you become eligible for Medicare; or,
- the child is no longer considered a dependent under this plan.

Notifying the State

You need to let your Human Resources/ Benefits Office know within 30 days of:

- a divorce;
- a child losing dependent status; or,
- disability determination by Social Security

Notify your Human Resources/Benefits Office within 30 days if Social Security determines you are no longer disabled.

After you notify your Human Resources/ Benefits Office, you will be sent information about COBRA and how much it costs. You can choose to continue coverage under COBRA. If you do, then you have the right to the same coverage as the active employees. If you don't, your coverage under this plan ends.

You should contact State of Delaware's COBRA Administrator if you have any questions.

When Your Coverage Under COBRA Ends

You can lose the coverage you continued under COBRA if:

- the State of Delaware no longer has any group health coverage;
- you don't pay the premium on time;
- you become eligible for Medicare or,
- you get coverage under another group plan. An exception may apply if the other plan:
  - has a preexisting condition waiting period; and,
  - provides credit for prior creditable coverage to offset the preexisting condition waiting period.

In such cases, you can be covered under both plans.

You are eligible to receive a standard Certificate of Coverage after you lose coverage under COBRA.

Coordination of Benefits

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

- Spouses
- Dependent Children
- Coordination of Benefits

Spouses

The benefits for spouses enrolled under this contracted health plan are as follows:

- We pay normal plan benefits if your spouse isn't employed.
- We pay after your spouse's plan pays if your spouse:
  - is eligible for, and,
  - is enrolled in a health benefit plan sponsored by his/her employer or by an organization from which he or she is collecting a pension benefit.
- We pay 20% of allowable covered charges if your spouse's employer provides a benefit plan, or an organization from which your spouse is collecting a pension provides a benefit plan, and your spouse:
  - is eligible for, and,
  - is not enrolled in that plan.

The combined payments can't be more than 100% of covered charges.

The above will not apply if your spouse is not enrolled in his/her employer's plan because your spouse:

- Doesn't work full time;
- Isn't eligible because he/she doesn't work enough hours to be eligible;
- Isn't eligible because he/she hasn't completed a waiting period;
- Has to pay more than 50% of the plan's cost (including flexible credits);
- Doesn't meet the underwriting requirements of the sponsored plan; or
- Is not offered health coverage at work.

You are responsible for completing a Spousal Continuation of Benefits form each year or at any time a spouse's job or health coverage status changes. The electronic Spousal Coordination of Benefits form is available at https://secomb.delaware.gov/cob/. The form must be completed and submitted online.

Dependent Children

You are responsible for completing a Dependent Coordination of Benefits form for each enrolled dependent regardless of age, any time the dependent is enrolled in other health coverage or upon request by the Statewide Benefits Office or Aetna. The Dependent Coordination of Benefits form is available at www.ben.omb.delaware.gov/medical/aetna/.

Coordination of Benefits (COB)

Terms

These terms are used to explain the rules for Coordination of Benefits (COB):

- Allowable Expense is a necessary, reasonable and usual health care expense. The expense must be covered at least in part by a plan that covers you.
- COB Provision sets the order in which plans pay when you're covered by two or more plans.
- Other Plans is any arrangement you have that covers your health care.
- Primary Plan is the plan applied before any other plan. Benefits under this plan are set without considering the other plan's benefits.
- Secondary Plan is the plan applied after the other plan. Benefits under this plan may be cut because of the other plan's benefits.

Order of Benefits Determination

The primary and secondary plan payments are set by these rules:

- A plan with no COB rules is primary over a plan with such rules.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.
- A plan that covers you as an active employee is primary over a plan that covers you as a non-active employee. Non-active means a laid-off or retired employee. This rule applies if you're the employee's dependent.
- For a child covered by plans under both parents, these rules apply:
  - The plan of the parent whose birthday comes first is primary.
  - If both parents have the same birthday, the plan that covered one parent longer is primary.
  - If the other plan does not have the parent birthday rule, the other plan's COB rules apply.
- If the parents are divorced or separated, this order applies:
  - First, the plan of the parent with custody;
  - Then, the plan of the spouse of the parent with custody; and,
  - Last, the plan of the parent not having custody.

This order can change by court decree. A court decree may make one parent responsible for the child's health care costs. If so, that parent's plan is primary.

- If these rules don't decide the primary plan, then the plan covering you longest is the primary.
- There may be two or more secondary plans. If so, these rules repeat until this plan's obligation for benefits is set.

Effect of Benefits

- When this plan is primary, we pay without regard to any secondary plan.
- When this plan is secondary, we account for payments made by other plans. We'll coordinate with the other plans. We'll make sure payments by all plans don't exceed the Allowable Expenses. Our payment will never be more than if we were primary.
- If the other plan is primary and reduces or does not cover benefits because there is coverage under this plan, then we'll calculate the benefit as if:
  - the State's plan is secondary; and,
  - the other plan has paid the normal payment.

IMPORTANT REMINDER: Keep in mind that you cannot receive coverage under this plan as:

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

Right To Receive And Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

Assignments

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

Misstatements

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

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

Subrogation and Right of Recovery Provision

Definitions

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

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

automobile Insurance Coverage, or any first party Insurance Coverage.

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

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim

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

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or

judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation

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

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

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Responsible Party. The plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation

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

Jurisdiction

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

Workers' Compensation

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

The Recovery Rights will be applied even though:

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

- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

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

Recovery of Overpayments

Health Coverage

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

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

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

Reporting of Claims

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

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

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

Payment of Benefits

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

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

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 physician provides care for you or a covered dependent, or care is provided by a network provider on referral by your physician (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/statede.

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 though 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 of 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 of 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 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 following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law; 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.

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 (External Review Organization)

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.

Appeal to the Plan

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

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

If you file a voluntary appeal, you will be deemed to authorize the Plan or its designee to obtain information from Aetna relevant to your claim.

Should you remain unsatisfied with the results of Aetna's review of your appeals and the External Review, you may within 20 days of the postmark of the results of the External Review request a fourth level appeal to the following address. Your fourth level appeal will be reviewed and you will receive a written response within 30 days of receipt of your request.

State of Delaware
Statewide Benefits Office
500 W. Loockerman Street, Suite 320
Dover, DE 19904
Phone: 1-800-489-8933 or 739-8331

Should you remain unsatisfied with the results of your fourth level appeal, you may within 20 days of the postmark of the Statewide Benefits Office notice of denial file a written request for a fifth level appeal to the State Employee Benefits Committee (SEBC) to the following address. Your fifth level appeal will be reviewed and you will receive a written response within 60 days of receipt of your request.

Chair, State Employee Benefits Committee
RE: Appeal
Office of Management and Budget
Haslet Armory, Third Floor, Suite 301
122 Martin Luther King Jr. Blvd. South
Dover, DE 19901

Should you remain unsatisfied with the results of your fifth level appeal, you may within 30 days of the postmark of the SEBC's notice of denial file a sixth level of appeal to the Delaware Superior Court.

Information on the State of Delaware's appeal process is available by calling 1-800-489-8933 or 739-8331 or can be reviewed at www.ben.omb.delaware.gov/medical/aetna/index.shtml

Your Rights and Responsibilities

Your Rights and Responsibilities

As a Plan participant, you can:

- Get up-to-date information about the doctors and hospitals participating in the Aetna's network.
- Obtain covered care from in-network and out-of-network physicians, specialists, hospitals and other providers.
- Get information from your doctors on how to make appointments and get health care during and after office hours.
- Call 911 (or any available area emergency response service) or go to the nearest emergency facility in a situation that might be life-threatening.
- Be treated with respect for your privacy and dignity.
- Have your medical records kept private, except when required by law or contract, or with your approval.
- Help your doctor make decisions about your health care.
- Discuss with your doctor your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.
- Get up-to-date information about the services covered by the Plan — for instance, what is and is not covered, and any applicable limitations or exclusions.
- Get information about any amounts you must pay.
- Be told how to file an appeal with the Plan.
- Receive a prompt reply when you ask the Plan questions or request information.

As a Plan participant, you have the responsibility to:

- Help your doctor make decisions about your health care.
- Follow the directions and advice you and your doctors have agreed upon.
- Tell your doctor promptly when you have unexpected problems or symptoms.
- Understand that participating doctors and other health care providers who care for you are not employees of Aetna and that Aetna does not control them.
- Show your ID card to providers as required.
- Pay the coinsurance required by the Plan.
- Call Member Services if you do not understand how to use your benefits.
- Give correct and complete information to doctors and other health care providers who care for you.
- Treat doctors and all providers, their staff, and the staff of the Plan with respect.
- Advise Aetna about other medical coverage you or your family members may have.
- Not be involved in dishonest activity directed to the Plan or any provider.
- Read and understand your Plan and benefits. Know what services are covered and what services are not covered.

Patient Self-Determination Act (Advance Directives)

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

What Is an Advance Directive?

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

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

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

What Is a Living Will?

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

The Living Will is a document that is limited to the withholding or withdrawal of life-sustaining procedures and/or treatment in the event of a terminal condition.

What Is a Durable Power of Attorney for Health Care?

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

A Durable Power of Attorney can be specific to a particular treatment or medical condition, or it can be very broad.

Who Decides About My Treatment?

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

How Do I Know What I Want?

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

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

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

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

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

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

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

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

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

Do I Have to Execute an Advance Directive?

No. It is entirely up to you.

Can I Change My Mind After Writing an Advance Directive?

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

What Is the Plan's Policy Regarding Advance Directives?

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

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

How Can I Get More Information About Advance Directives?

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

Glossary

A

Accident

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

Aetna

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

Ambulance

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

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

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

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

E

Emergency Care

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

Emergency Medical Condition

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

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

Experimental or Investigational

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

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

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

G

Generic Prescription Drug

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

H

Homebound

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

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

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

You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or

You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency

An agency that meets all of the following requirements.

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

Home Health Care Plan

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

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

Hospice Care

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

Hospice Care Agency

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

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

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

Hospice Care Program

This is a written plan of hospice care, which:

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

Hospice Facility

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

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

Hospital

An institution that:

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

Hospitalization

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

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.

I

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

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

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

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

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

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

Institutes of Quality® (IOQ)
Institutes of Quality® Bariatric Surgery facilities are a national network of health care facilities that are designated based on measures of clinical performance, access and efficiency for bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity.

J

Jaw Joint Disorder
This is:

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

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 during their lifetime.

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

M

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

Maintenance Care
Care made up of services and supplies that:

- Are furnished mainly to maintain, rather than to improve, a level of physical, or mental function; and

- Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity

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

a. In accordance with generally accepted standards of medical or dental practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. Not primarily for the convenience of the patient, physician, other health care or dental provider; and

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

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

Mental Disorder

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

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 Mental Developmental Disorder (including Autism).
- Psychotic Disorders/Delusional Disorder.
- Schizo-affective Disorder.
- Schizophrenia.

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

Morbid Obesity

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

N

Negotiated Charge

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

Network Advanced Reproductive Technology (ART) Specialist

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

Network Provider

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

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

Network Service(s) or Supply(ies)

Health care service or supply that is:

- Furnished by a network provider

Night Care Treatment

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

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

Non-Occupational Illness

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

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

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

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

Non-Occupational Injury

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

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

Non-Specialist

A physician who is not a specialist.

Non-Urgent Admission

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

O

Occupational Injury or Occupational Illness

An injury or illness that:

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

Occurrence

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

- Receives no medical treatment; services; or supplies; for a disease or injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or injury.

Orthodontic Treatment

This is any:

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

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

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

whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

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

Other Health Care

A health care service or supply that is neither network service(s) or supply(ies) nor out-of-network service(s) and supply(ies). Other health care can include care given by a provider who does not fall into any of the categories in your provider directory (or in DocFind at Aetna's website).

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

Health care service or supply that is:

- Furnished by an out-of network provider; or
- Not other health care.

Out-of-Network Provider

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

P

Partial Confinement Treatment

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

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

Payment Percentage

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

Payment Limit

- Payment limit is the maximum out-of-pocket amount you are responsible to pay for your payment percentage for covered expenses during your plan year. Once you satisfy the payment limit, the plan will pay 100% of the covered expenses that apply toward the limit for the rest of the plan year. The payment limit applies to both network and out-of-network benefits.

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.

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.

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 infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a physician who:

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

R

Recognized Charge

Only that part of a charge which is less than or equal to the recognized charge is a covered benefit. The recognized charge for a service or supply is the lowest of

- The provider's usual charge for furnishing it; and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, billed or coded; or
  a. For non-facility charges: Aetna uses the provider charge data from the Ingenix Incorporated Prevailing HealthCare Charges System (PHCS) at the 80th percentile of PHCS data. This PHCS data is generally updated at least every six months.
  b. For facility charges: Aetna uses the charge Aetna determines to be the usual charge level made for it in the geographic area where it is furnished

In determining the recognized charge for a service or supply that is:

- Unusual; or
- Not often provided in the geographic area; or
- Provided by only a small number of providers in the geographic area;

Aetna may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The recognized charge in other geographic areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

As used above, the term "geographic area" means a Prevailing HealthCare Charges System (PHCS) expense area grouping. Expense areas are defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, PHCS never crosses state lines. This data is produced semi-annually. Current procedure codes that have been developed by the American Medical Association, the American Dental Association, and the Centers for Medicare and Medicaid Services are utilized.

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:

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

- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Residential Treatment Facility (Substance Abuse)

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

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

R.N.

A registered nurse.

Room and Board

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

S

Semi-Private Room Rate

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

Service Area

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

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
  - Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

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

Skilled nursing facility does not include:

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

Skilled Nursing Services

Services that meet all of the following requirements:

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

Specialist

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

Specialty Care

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

Stay

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

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or

treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

Must have all of the following:

- A physician trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

T

Terminally Ill (Hospice Care)

Terminally ill means a medical prognosis of 12 months or less to live.

U

Urgent Admission

A hospital admission by a physician due to:

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

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by

physicians other than those who own or direct the facility.

  - Is run by a staff of physicians. At least one physician must be on call at all times.
  - Has a full-time administrator who is a licensed physician.
- A physician's office, but only one that:
  - Has contracted with Aetna to provide urgent care; and
  - Is, with Aetna's consent, included in the directory as a network urgent care provider.
- It is not the emergency room or outpatient department of a hospital.

Urgent Condition

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

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

W

Walk-in Clinic

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

Important Health Care Reform Notices

Choice of Provider

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

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

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

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, www.cms.gov/HealthInsReformforConsume/, and this U.S. Department of Labor website, www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

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

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

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

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

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

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Aetna CDH Gold Plan Examples

Manage your health care and health care spending

The following pages give examples of how the Aetna CDH Gold Plan works over a two-year period for both an individual and a family.

Aetna CDH Gold Plan with an HRA Fund: Employee-Only Plan

Here is an example of how the Aetna CDH Gold Plan with an HRA Fund works over two years.

This example is for an employee-only plan:

- You use in-network doctors and hospitals
- Preventive care is covered at 100 percent and does not count toward your deductible
- The State of Delaware contributes $1,250 to the fund
- The Aetna CDH Gold Plan has a $1,500 deductible

Year One

- You visit your doctor for a routine physical exam. The exam charge is $100. The Aetna CDH Gold Plan covers preventive care at 100 percent. So, you pay nothing and nothing is paid from the HRA fund.
- Later in the year, you sprain your ankle. During the office visit, your doctor takes X-rays. Your total expense is $300 — $175 for the X-rays and $125 for the office visit.
- If you have not yet met your deductible, you are responsible for paying that $300. Under the Aetna CDH Gold Plan, this amount is paid in full out of the HRA fund. That means you pay nothing out of your own pocket, and the amount paid from the fund reduces your deductible. Your remaining deductible is $1,200. You have no other health care expenses for the rest of the year.
- At the end of Year One, $950 remains in the fund. That amount will be rolled over to the next year if you remain enrolled in a CDH Gold Plan through the State of Delaware.

Example: Employee Only, Plan Year One

Here is the plan	
The HRA fund:	**$1,250**
Health plan deductible:	$1,500
After deductible is met:	
Health plan pays:	90% (In-network)
You pay:	10% (In-network)

A look at Year One	
Total expenses:	**$400**
The HRA fund:	
You start with:	$1,250
You use:	$300
Remaining HRA fund:	***$950***
Total amount paid by plan:	**$100**
Total amount paid by the HRA fund:	**$300**
Total amount you paid:	**$0**
HRA fund roll-over to the next plan year:	**$950**

Year Two

- Early in the year, you need surgery. The cost is $9,200.
- You start the year with $2,200 in the HRA fund. This includes $1,250 from the State of Delaware for this year's HRA fund plus $950 rolled over from last year's HRA fund. If you have not yet met your $1,500 deductible, you must pay that $1,500 out of your pocket first.
- Now that you've met your deductible, there is a balance of $7,700 to pay for surgery.
- The health plan now begins to pay. You visited in-network doctors and facilities. So, your health plan pays 90 percent of the balance ($6,930) and you are responsible for 10 percent ($770). However, the HRA fund pays $700 and you are responsible for $70.
- At the end of Year Two, the fund balance is $0. You'll start Year Three with a new HRA fund balance of $1,250 if you remain in a CDH Gold Plan through the State of Delaware.

Example: Employee Only, Plan Year Two

A look at Year Two	
Total expenses	**$9,200**
The HRA fund:	
Year Two employer contribution:	$1,250
Amount rolled over from Year One:	$950
Year Two starting HRA fund balance:	$2,200
You use:	$1,500
Remaining expenses:	***$7,700***

Your deductible	
Health plan deductible (Year Two):	$1,500
Amount paid from the HRA fund:	$1,500
Remaining balance of expenses:	$7,700
Amount you paid to meet the deductible:	$0
Remaining expenses:	***$7,700***

Your health plan	
Amount paid by plan (90% of $7,700):	$6,930
Balance due (10% of $7,700):	$770
Amount paid by the HRA fund:	$700
Remaining expenses:	***$0***
Total amount paid by plan:	**$6,930**
Total amount paid by the HRA fund:	**$2,200**
Total amount you paid:	**$70 (your share of the health costs)**

Aetna CDH Gold Plan with an HRA Fund: Family Plan

Here is another example of how the Aetna CDH Gold Plan with an HRA Fund works over two years.

This example is for a family plan:

- Your family uses both in- and out-of-network doctors and hospitals
- Preventive care is covered at 100 percent and does not count toward your deductible
- The State of Delaware contributes $2,500 to the HRA fund at the family level
- The Aetna CDH Gold Plan has a $3,000 family deductible (the family deductible can be met by two or more family members, but no one individual is charged more than the individual $1,500 limit)

Year One

- You visit an out-of-network specialist for an exam and testing. The charge is $1,000.
- If you have not yet met your family deductible, you are responsible for paying that $1,000. Under the Aetna CDH Gold Plan, this amount is paid in full out of the HRA fund. That means you pay nothing out of your own pocket, and the amount paid from the HRA fund reduces the family deductible. Your remaining family deductible is $2,000.
- Later in the year, your spouse has surgery performed by an in-network doctor. The charge is $1,000.
- Since your family deductible has not been met, you are responsible for paying that $1,000. But again, under the Aetna CDH Gold Plan, this amount is paid in full out of the HRA fund and you pay nothing out of your own pocket. The amount paid from the HRA fund reduces the family deductible. Your remaining family deductible is now $1,000, and your remaining HRA fund balance is $500.
- Your family has no other health care expenses for the rest of the year.
- At the end of Year One, $500 remains in the HRA fund. That amount will be rolled over to the next year if you remain enrolled in a CDH Gold Plan through the State of Delaware.

Example: HRA Fund at the Family Level, Plan Year One

Here is the plan	
The HRA fund:	**$2,500**
Health plan deductible:	$3,000
After deductible is met:	
Health plan pays:	90% (In-network) 70% (Out-of-network)
You pay:	10% (In-network) 30% (Out-of-network)

A look at Year One	
Total expenses:	**$2,000**
The HRA fund:	
You start with:	$2,500
You use:	$2,000
Remaining HRA fund:	***$500***
Total amount paid by plan:	**$0**
Total amount paid by fund:	**$2,000**
Total amount you paid:	**$0**
HRA roll-over to next plan year:	**$500**

Year Two

- Your daughter has surgery performed by an in-network doctor at an in-network surgical facility. The charge is $5,000.
- You start the year with $3,000 in the HRA fund at the family level. This includes $2,500 from the State of Delaware for this year plus $500 rolled over from last year into your HRA fund.
- Your $3,000 family deductible has not been met yet; however, no one person must meet more than the $1,500 individual deductible. Under the Aetna CDH Gold Plan, the HRA fund pays $1,500 toward your family deductible, leaving a balance of $1,500 remaining in the HRA fund.
- Now that your daughter's portion of the family deductible has been met, there is a balance of $3,500 to pay for the surgery.
- The health plan now begins to pay. Your daughter visited an in-network doctor and facility, so, your health plan pays 90 percent of the balance ($3,150) and you pay 10 percent ($350). Under the Aetna CDH Gold Plan, your amount ($350) is paid in full out of the HRA fund.
- Your family has no other health care expenses for the rest of the year.
- At the end of Year Two, the HRA fund balance is $1,150. You'll start Year Three with a new HRA fund balance of $3,650 if you remain enrolled in a CDH Gold Plan through the State of Delaware.

Example: HRA Fund at the Family Level, Plan Year Two

A look at Year Two	
Total expenses:	**$5,000**
The HRA fund:	
Year Two employer contribution:	$2,500
Amount rolled over from Year One:	$500
Year Two starting fund HRA balance:	$3,000
You use:	$1,500
Remaining expenses:	***$3,500***

Your deductible:	
Health plan family deductible (Year Two):	$3,000
Amount paid from the fund:	$1,500
Remaining balance of expenses:	$3,500
Amount you paid to meet the deductible:	$0
Remaining expenses:	***$3,500***

Your health plan:	
Amount paid by plan (90% of $3,500):	$3,150
Balance due (10% of $3,500):	$350
Amount paid by HRA fund:	$350
Remaining expenses:	***$0***
Total amount paid by plan:	**$3,150**
Total amount paid by HRA fund:	**$1,850**
Total amount you paid:	**$0**
HRA roll-over to next plan year	**$1,150**

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

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